TAHOE FOREST
HOSPITAL DISTRICT

2026-03-26 Regular Meeting of the Board of Directors

Thursday, March 26, 2026, at 4:00 p.m.

Tahoe Forest Hospital - Eskridge Conference Room

10121 Pine Avenue, Truckee, CA 96161

https://tfhd.zoom.us/j/81070388983

TAHOE FOREST
HOSPITAL DISTRICT

Meeting Book - 2026-03-26 Regular Meeting of the Board of Directors

Agenda Packet Contents

TAHOE FOREST
HOSPITAL DISTRICT

REGULAR MEETING OF THE BOARD OF DIRECTORS

AGENDA

Thursday, March 26, 2026, at 4:00 p.m.
Tahoe Forest Hospital – Eskridge Conference Room
10121 Pine Avenue, Truckee, CA 96161
Telephonic Location GC 54953(b): 7524 Homing Pigeon, Las Vegas, Nevada 89084

If you would like to view the meeting or speak on an agenda item, you can access the meeting remotely:
Please use this web link: https://tfhd.zoom.us/j/81070388983

Or join by phone:
If you prefer to use your phone, you may call in using the numbers listed:
(669) 900 6833 or (669) 444 9171
Meeting ID: 810 7038 8983

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

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

1. **CALL TO ORDER**

2. **ROLL CALL**

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

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

5. **CLOSED SESSON**
   - **5.1. Approval of Closed Session Minutes**◈
     - **5.1.1.** 02/26/2026 Regular Meeting
     - **5.1.2.** 03/04/2026-03/05/2026 Special Meeting
   - **5.2. Liability Claims (Gov. Code § 54956.95)**◈
     Claimant: Jeffrey D. Cisneros
     Claim Against: Tahoe Forest Hospital District

◈ Denotes Action Item

5.3. Report Involving Trade Secrets (Health & Safety Code § 32106)
Discussion will concern: Existing and potential new programs and service lines
Estimated date of disclosure: December 2026

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

6. DINNER BREAK

APPROXIMATELY 6:00 P.M.

7. OPEN SESSION – CALL TO ORDER

7.1. Meeting Dedication in honor of Greg Tarter

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 act on any item not on the agenda. The Board Chair may choose to acknowledge the comment or, where appropriate, briefly answer a question, refer the matter to staff, or set the item for discussion at a future meeting.

11. INPUT FROM EMPLOYEE ASSOCIATIONS

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

12. PRESIDENT & CEO – MONTHLY HIGHLIGHTS

12.1. Monthly Highlights ..... ATTACHMENT
President & CEO Anna M. Roth will provide an update highlighting key developments, initiatives, and recent activities impacting the District.

13. MEDICAL STAFF EXECUTIVE COMMITTEE◈

13.1. Medical Executive Committee (MEC) Meeting Consent Agenda ..... ATTACHMENT
MEC recommends the following for approval by the Board of Directors:

Policies with Changes:

- *Emergency Department Policies*
- *IVCH ED Policies*
- *Infection Control Policies*
- *Quality Assurance/ Performance Improvement Policies*
- *Employee Health Policies*
- *Environment of Care Policies*

Annual Plan Approval

- *Medication Error Reduction Plan, APH-34*
- *Quality Assessment/ Performance Improvement Plan, AQPI-05*

◈ Denotes Action Item

- *Risk and Patient Safety Plan, AQPI-02*
- *Trauma Performance Improvement Plan*
- *Utilization Review Plan, DCM-1701*
- *Available CAH Services, TFH & IVCH, AGOV-06*

14. CONSENT CALENDAR ◈

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

14.1. Approval of Minutes of Meetings
14.1.1. 02/26/2026 Regular Meeting ..... ATTACHMENT
14.1.2. 03/04/2026-03/05/2026 Special Meeting ..... ATTACHMENT
14.2. Financial Reports ..... ATTACHMENT
14.2.1. Financial Report – February 2026 ..... ATTACHMENT
14.3. Board Reports ..... ATTACHMENT
14.3.1. Executive Board Report – March 2026 ..... ATTACHMENT
14.4. Board Policy Review ..... ATTACHMENT
14.4.1. Plan for the Provision of Care to Patients, AGOV-26 ..... ATTACHMENT
14.4.2. Hand-Off Communications SBAR and C-U-S Reports, AGOV-1504 ..... ATTACHMENT
14.4.3. Medical Device Tracking, AGOV-1605 ..... ATTACHMENT
14.4.4. Physician and Professional Services Agreement, ABD-21 ..... ATTACHMENT
14.4.5. Available CAH Services, TFH & IVCH, AGOV-06 ..... ATTACHMENT
14.5. Quality Assessment/Performance Improvement (QA/PA) Plan, AQPI-05 Policy ..... ATTACHMENT
14.6. Affirm Board Committee Charters ..... ATTACHMENT
14.6.1. Board Executive Compensation Committee Charter ..... ATTACHMENT
14.7. Ratify TFHS Foundation Board Member ..... ATTACHMENT
14.7.1. Lynne Weakley ..... ATTACHMENT

15. TIMED ITEMS FOR BOARD DISCUSSION

15.1. Sports Medicine Presentation - Athletic Training Month ..... ATTACHMENT
The Board of Directors will receive a presentation from the Sports Medicine Department.

16. ITEMS FOR BOARD ACTION ◈

16.1. Disruption of Telephonic or Internet Service During Public Meetings, ABD-2601 ..... ATTACHMENT
New Board policy recommended for approval by the Governance Committee, required by the passage of SB 707.

16.2. Community Outreach for Underserved Communities and Hospital Board Meeting Engagement, ABD-2602 ..... ATTACHMENT
New Board policy recommended for approval by the Governance Committee, required by the passage of SB 707.

16.3. Guideline for Business by the Tahoe Forest Hospital District Board of Directors, ABD-12 ..... ATTACHMENT
Revised Board policy with significant edits recommended for approval by the Governance Committee, required by the passage of SB 707.

◈ Denotes Action Item

17. DISCUSSION OF CONSENT CALENDAR ITEMS PULLED, IF NECESSARY

18. BOARD COMMITTEE REPORTS

19. BOARD MEMBERS' REPORTS/CLOSING REMARKS

20. CLOSED SESSION CONTINUED, IF NECESSARY

21. OPEN SESSION

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

23. ADJOURN

Tahoe Forest Hospital District has enabled live captioning and live Spanish translation in Zoom. To turn on live captions (subtitles) follow these steps:
1. In your Zoom meeting, look at the bottom toolbar.
You will see one of the following buttons:
- Captions
- Show Captions
- CC / Live Transcript

2. Click the button and select:
- Show Captions

3. To turn On Spanish Translation (live interpreted captions)
- Click the small arrow (^) next to the Captions button.
- Toggle the Translation button to the "on" position.
- Select: Caption Language
- Choose: Spanish

The next regularly scheduled meeting of the Board of Directors of Tahoe Forest Hospital District is April 23, 2026 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, 10800 Donner Pass Rd, suite 200, 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 (530) 582-3583 at least 24 hours in advance of the meeting.

President and CEO Monthly Highlights

Anna M. Roth, RN, MSN, MPH

March 2026

TAHOE FOREST
HEALTH SYSTEM

Health within reach

Personnel Announcement

→ Chief of Clinic Operations

Primary care & pediatrics redesign anchored in data

→ Full mapping of third next available appointment (TNA) by provider, visit type, and department

Real-time access dashboard

→ Tracks current performance and trends future demand

→ Shifts access from reactive scheduling

→ Active system management

Predictive model for Pediatrics (nearly complete)

→ Anticipates community need and aligns capacity in real time

→ Creates a forward-looking view of access gaps before they occur

TAHOE FOREST
HEALTH SYSTEM

Health within reach

Primary Care predictive model (in development)

→ Extending the same approach across the largest access point in the system

Test-and-iterate improvement strategy

→ Small, care-team-level pilots vs. broad department changes

→ Faster learning, lower disruption, scalable solutions

Community-informed design (starting April)

→ Patients helping shape how care is accessed and delivered

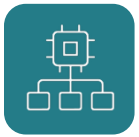
Workforce housing (300 employees supported)

→ Enabling staffing levels required to expand access

TAHOE FOREST
HEALTH SYSTEM

Transformation

Advancing systems, culture, and long-term performance



AI-enabled documentation + workflow tools

→ Reducing friction, improving provider experience

Formal project governance model

→ Fewer priorities, stronger execution discipline

Executive rounding (~60% coverage)

→ Embedding feedback loops + leadership visibility

Leadership recruitment (ops, community health, hospice)

→ Update on recruitment for Chief Human Resources Officer

→ Building depth in critical capabilities

TAHOE FOREST
HEALTH SYSTEM

Transformation

Advancing systems, culture, and long-term performance

Recognition + culture of performance (nursing awards)

→ Reinforcing standards and engagement

Cybersecurity + system reliability

→ Protecting operations and enabling scale

Nevada Rural Health Transformation participation

→ External leverage for workforce + system innovation

Climate Action Plan

→ Aligning long-term system design with community expectations

TAHOE FOREST
HEALTH SYSTEM

2026 Board Retreat Recap

Healthcare Environment

- Hospitals face increasing financial and operational pressures
- Regulatory and reimbursement uncertainty at state and federal levels
- Rising costs for labor, supplies, and pharmaceuticals
- Shift toward outpatient and whole-person care models
- Importance of planning for long-term sustainability

TAHOE FOREST
HEALTH SYSTEM

2026 Board Retreat Recap

Review of Best Practices

- Effective governance supports accountability and performance
- Importance of Board structure, composition, and meeting practices
- Governance as a foundation for strategic oversight

TAHOE FOREST
HEALTH SYSTEM

2026 Board Retreat Recap

Fiduciary Responsibilities

- Board members have a duty to act in the best interest of the community
- Stewardship of public resources and assets
- Compliance with laws, regulations, and transparency requirements
- Maintaining public trust through ethical oversight

TAHOE FOREST
HEALTH SYSTEM

2026 Board Retreat Recap

Summary

- Retreat provided space for thoughtful discussion and reflection
- Focused on healthcare challenges, governance, and accountability
- Reinforced commitment to strong oversight and public service
- Insights will guide future Board discussions

TAHOE FOREST
HEALTH SYSTEM

Questions?

TAHOE FOREST
HOSPITAL DISTRICT

AGENDA ITEM COVER SHEET

MEETING DATE: March 26, 2026	**ITEM:** Medical Executive Committee (MEC) Consent Agenda
DEPARTMENT: Medical Staff	**TYPE OF AGENDA ITEM:** ☐ Action ☒ Consent ☐ Discussion
RESPONSIBLE PARTY: Johanna Koch, MD, Chief of Staff	**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:
Respective Departments have reviewed Department Policies and Privileges, recommended approval to MEC. During the March 19, 2026 Medical Executive Committee meeting, the MEC reviewed and made the following open session consent agenda item recommendations to the Board of Directors for the March 26, 2026 Regular Meeting of the Board of Directors.

SUMMARY/OBJECTIVES:

Policies with Changes:

- Emergency Department Policies
- IVCH ED Policies
- Infection Control Policies
- Quality Assurance/ Performance Improvement Policies
- Employee Health Policies
- Environment of Care Policies

Annual Plan Approval

- Medication Error Reduction Plan
- Quality Assessment/ Performance Improvement Plan
- Risk and Patient Safety Plan
- Trauma Performance Improvement Plan
- Utilization Review Plan
- Annual CAH Services

SUGGESTED DISCUSSION POINTS:
Medical Executive Committee has reviewed the Department recommendations on privileges and policies. 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:

Policies with Changes:

- Emergency Department Policies
- IVCH ED Policies
- Infection Control Policies
- Quality Assurance/ Performance Improvement Policies
- Employee Health Policies
- Environment of Care Policies

Annual Plan Approval

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Title	Department	Last Approved	Next Review	Summary of Changes
Admission of Obstetrical Patient, DED-3	Emergency Department - DED	1/27/2026	1/27/2028	changes "if parts are present on outside of perineum" to if "delivery is deemed imminent" Removed "Patient's private physician will be contacted"
EPIC Downtime, DED-46	Emergency Department - DED	1/27/2026	1/27/2028	Updated required downtime charting to include triage and patient assessment
Laboratory Tests, DED-14	Emergency Department - DED	1/27/2026	1/27/2028	Removed whole blood, TFH does not have it. Removed that the RNs need to complete blood order form, this is only in CMT and is covered in that policy
Ski Resort First Aid Stations, DED-1905	Emergency Department - DED	1/27/2026	1/27/2028	Updated correct title for Medical Director of Ski Clinics. Removed treatment guidelines, treatment guidelines are outlined in the ski area CPG
Triage Charting Standards, DED-7	Emergency Department - DED	1/27/2026	1/27/2028	Current medications changed to medication reconciliation. Sepsis screening added.
Vital Signs, DED-43	Emergency Department - DED	1/27/2026	1/27/2028	changed age that blood pressures must be taken
Laboratory Results Culture Screening, DED-13	Emergency Department - DED	1/27/2026	1/27/2027	No changes
Law Enforcement Medical Clearances, DED-15	Emergency Department - DED	1/27/2026	1/27/2027	No changes
Level 3 Trauma Activation, DED-1901	Emergency Department - DED	1/27/2026	1/27/2027	Changed notification process for Modified trauma to overhead page instead of separate phone calls, process changed in 2025.
Admission of Emergency Department Patient, DED-2	Emergency Department - DED	1/27/2026	1/27/2027	Took out no fly zone language and replaced it with "according to agreed upon guidelines and timing". Took out required forms for admission, not complete list and unnecessary in policy.

Title	Department	Last Approved	Next Review	Summary of Changes
CPAP BiPAP, DEDI-1901	Incline Village Emergency Department - DEDI	3/9/2026	3/8/2028	• Added reference to Dynamic Health for clinical guidance • Clarified pediatric limitations due to equipment availability • Removed standalone contraindications list (addressed within the Dynamic Health resource) • Formatting updated to improve clarity and usability • Added attachment (Dynamic Health) and related policies/forms (DEDI-237) Approved by Emergency Chair Dr Gladman and IVCH ED Medical Director Dr Young.

Title	Department	Last Approved	Next Review	Summary of Changes	Summary of Changes
Infection Prevention and Control Plan, AIPC-64	Infection Prevention and Control - AIPC	2/19/2026	12/31/2026	no major edits. updated attachements	Removed paramedical 2e

Title	Department	Last Approved	Next Review	Summary of Changes
Consent, Informed, AQPI-1907	Quality Assurance / Performance Improvement - AQPI	2/17/2026	2/16/2029	Added Notice of Release of Psychotherapeutic Drug Informed Consent Form AFL 25-38.1 statement and form
Quality Assessment/ Performance Improvement (QA/PI) Plan, AQPI-05	Quality Assurance / Performance Improvement - AQPI	3/11/2026	3/11/2027	Approved with changes by BOD QAC on 2/11/26 and MS QAC on 2/24/26. MEC approval on 3/19/26 and BOD on 3/26/26.

Title	Department	Last Approved	Next Review	Summary of Changes
Employee Health Plan, DEH-39	Employee Health - DEH	12/4/2025	12/4/2026	Removed HFAP reference, now ACHC
Influenza Prevention, DEH-2001	Employee Health - DEH	12/4/2025	12/4/2026	removed reference to HFAP, now ACHC

Title	Department	Last Approved	Next Review	Summary of Changes
Emergency Management Plan, AEOC-14	Environment of Care - AEOC	1/14/2026	1/14/2027	Updated Performance Improvements.
Emergency Operations Plan, AEOC-17	Environment of Care - AEOC	1/28/2026	1/28/2027	Formatting and clarification changes. Updated Annex 2 according to Code Triage procedures.
Environment of Care Management Program, AEOC-908	Environment of Care - AEOC	1/28/2026	1/28/2027	Changed HFAP to ACHC.

Status **Active** PolicyStat ID **13545691**

Origination Date	02/2009	Department	Pharmacy - APH and DPH
Last Approved	03/2024	Applicabilities	System
Last Revised	03/2024		
Next Review	03/2026		

Medication Error Reduction Plan, APH-34

RISK:

Medication errors are known to be a significant cause of morbidity and mortality in hospitalized patients as well as contributing to an increase in the cost of healthcare nationwide. A proactive approach will be taken to minimize the occurrence of medication errors in the health system.

POLICY:

A. It is the policy of Tahoe Forest Hospital District to take a proactive approach to reduce medication errors and improve patient safety by focusing on system and performance improvement activities related to medication use.

B. Tahoe Forest Hospital District will evaluate, assess and address the following eleven (11) elements:

1. Prescribing
2. Order Communication
3. Product Labeling
4. Product Packaging and Nomenclature
5. Compounding
6. Dispensing
7. Distribution
8. Administration
9. Education
10. Monitoring
11. Use

PROCEDURES:

A. There is a robust medication error reporting system that identifies and captures potential and actual medication errors both concurrently and retrospectively by:
    1. Non-punitive self reporting by staff and physicians
    2. Pharmacist daily review of the Pyxis override list and comparing the medications removed and administered match the physician order
    3. Random chart audits
    4. Daily Medication Administration Record review performed by Nursing
    5. Medication Pass Observations

B. Please refer to the policy Medication Error Reporting for more information related to Medication Error reporting.

C. TFHD utilizes the Medication Safety Committee, a multi-disciplinary team that includes representation from all clinical areas in the District that meets every other month, to objectively identify opportunities to change current procedures and systems to reduce medication errors.

D. This will be accomplished by the Committee:
    1. Review and make recommendations related to medication polices
    2. Review and make recommendations related to preprinted orders
    3. Analyze trends of medication errors and adverse drug events.
    4. Recommend system, technology and policy and procedure changes that will improve patient safety
    5. Evaluate and implement plans to address applicable external medication-related alerts from a variety of sources ~~including but not limited to~~such as:
        a. California State Board of Pharmacy
        b. Institute for Safe Medication Practice
        c. Federal Food and Drug Administration
        d. ~~The Healthcare Facilities Accreditation Program~~
        e. American Society of Hospital pharmacists
        f. California Department of Public Health.
    6. Assessing the effectiveness of medication safety enhancement plans and actions taken by monitoring medication error related metrics.
    7. Methods to determine effectiveness will provide objective and relevant evidence that informs policy decision in the evaluation and development of corrective actions to effectively reduce medication errors.
    8. At a minimum, annually reviews the District's Medication Error Reduction Plan and modify the plan when weaknesses or deficiencies are noted to achieve a reduction of medication errors.
    9. At a minimum, annually reviews the District's High Alert list of medications and

Sound Alike Look Alike (SALA) medications.

a. Please refer to the High Alert Medication policy.

Responsibility:

It is the responsibility of the designated Medication Safety Officer in partnership with the Director of Pharmacy and the Quality Department to maintain the Medication Error Reduction Plan.

Related Policies/Forms:

Medication Error Reporting, APH-24, High Alert Medications, APH-15

References:

California Codes Health and Safety Code 1339.63, HFAP Standards 06.01.01, 09.00.08, 09.01.04, 09.01.05, 09.01.06, 09.01.07, 15.00.00

All Revision Dates

03/2024, 04/2021, 05/2019, 04/2016, 01/2015, 01/2014, 11/2013, 09/2010

Approval Signatures

Step Description	Approver	Date
	Jim Franckum: Director of Pharmacy	03/2024
	Jim Franckum: Director of Pharmacy	03/2024

Status **Draft** PolicyStat ID **19296284**

Origination Date	N/A
Last Approved	N/A
Last Revised	N/A
Next Review	N/A

Department	Quality Assurance / Performance Improvement - AQPI
Applicabilities	System, Truckee Surgery Center

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

RISK:

~~Organizations who respond reactively, instead of pro-actively, to unanticipated adverse events, and/or outcomes, lack the ability to mitigate organizational risks by reducing or eliminating contributing factors. This is a risk for poor quality care and patient outcomes.~~

Risks to patient safety, clinical outcomes, operational efficiency, and regulatory compliance may arise from variations in care delivery, human factors, system failures, environmental conditions, or breakdowns in communication. These risks have the potential to result in patient harm, decreased quality of care, workflow inefficiencies, financial loss, or reputational damage if not proactively identified and managed.

POLICY:

The Quality Assessment/Performance Improvement (QA/PI) plan provides a framework for promoting and sustaining performance improvement at Tahoe Forest Health System, in order to improve the quality of care and enhance organizational performance. An effective plan will pro-actively mitigate organizational risks by eliminating, or reducing factors that contribute to unanticipated adverse events and/or outcomes, in order to provide the highest quality care and service experience for our patients and customers.This will be accomplished through the support and involvement of the Board of Directors, Administration, Medical Staff, Management, and employees, in an environment that fosters collaboration and mutual respect. This collaborative approach supports innovation, data management, performance improvement, proactive risk assessment, commitment to customer satisfaction, and High Reliability principles to promote and improve awareness of patient safety. Tahoe Forest Health System has an

established mission, vision, values statement, and utilizes a ~~foundation of excellence~~winning aspirations model, which are utilized to guide all improvement activities.

MISSION STATEMENT

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

VISION STATEMENT

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

VALUES STATEMENT

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

A. Quality – holding ourselves to the highest standards, committing to continuous improvement, and having personal integrity in all we do
B. Understanding – being aware of the concerns of others, demonstrating compassion, respecting and caring for each other as we interact
C. Excellence – doing things right the first time, every time, and being accountable and responsible
D. Stewardship – being a community partner responsible for safeguarding care and management of health system resources while being innovative and providing quality healthcare
E. Teamwork – looking out for those we work with, findings ways to support each other in the jobs we do

WINNING ASPIRATIONS

A. Our winning aspirations includes:
    1. Community – aspire to be an integrated partner in an exceptionally healthy and thriving community
    2. Service – aspire to deliver a timely, outstanding patient and family experience
    3. Quality – aspire to deliver the best possible outcomes for our patients
    4. People – aspire for a highly engaged culture that inspires teamwork and joy
    5. Finance – aspire for long-term financial strength

PERFORMANCE IMPROVEMENT INITIATIVES

A. The ~~2025~~2026 performance improvement priorities are based on the principles of STEEEP™, (Safe, Timely, Effective, Efficient, Equitable, Patient Centered Care) and the ~~Quadruple~~Quintuple Aim (IHI, 2022):

1. Improving the patient experience of care (including quality and satisfaction);
2. Improving ~~the~~population health ~~of populations~~;
3. Reducing the per capita cost of health care;
4. ~~Staff engagement and joy in work.~~
5. Improving workforce well-being;
6. Advancing health equity.

B. Priorities identified include:
    1. Exceed national ~~benchmark with~~benchmarks for quality of care and patient satisfaction ~~metric results with a focus~~by focusing on process improvement and performance excellence .
        a. ~~Striving for the Perfect Care Experience~~
        b. Achieve bronze level Geriatric Emergency Department accreditation (GEDA)
        c. Strengthen access to care and provider capacity by reducing appointment delays and improving same day access
        d. Highlight standard work process improvement, utilizing improvement science principles, to improve quality, access, and efficiency
        e. Emphasis on health equity in order to attain the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes (Health equity | CMS).
        f. Identify and promote best practice and evidence-based medicine in every service line
        g. Focus on CMS quality ~~star~~Star rating improvements, within the measure groups~~,~~ that fall below benchmark
        h. ~~Highlight Management Systems and standard work process improvement, utilizing lean principles, to improve quality, access, and efficiency~~
        i. ~~Emphasis on health equity in order to attain the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes (Health equity | CMS).~~
        j. Improving care coordination and reducing avoidable readmissions and hospital transfers
    2. ~~Continued focus on quality and patient/employee safety related to infectious diseases, following CDC, State, and County Health guidelines, and utilizing the following strategies:~~

~~a. Strengthen the system and environment~~
~~b. Support patient, family, and community engagement and empowerment~~
~~c. Improve clinical care~~
~~d. Reduce harm~~
~~e. Boost and expand the learning system~~Continued focus on quality and patient/ employee safety related to infectious diseases by adhering to State, County Health, and Federal requirements. These efforts will be supported through proactive prevention, early detection, rapid response, and ongoing education to protect patients, staff, and the wider community.

3. Ongoing survey readiness, and compliance with federal and state regulations, resulting in a successful triennial ~~General Acute~~Accreditation Commission for Health Care ~~Hospital Relicensing~~ (~~GACHLRS~~ACHC) ~~and Rural Health Clinic~~ re-accreditation survey
4. Sustain a culture of safety, transparency, accountability, and system improvement
    a. Continued participation in Beta HEART (Healing, Empathy, Accountability, Resolution, Trust) program
    b. Conduct annual Culture of Safety SCORE (Safety, Culture, Operational, Reliability, and Engagement) survey
    c. Continued focus on the importance of event reporting, including near misses
5. Focus on our culture of safety, across the entire Health System, utilizing High Reliability Organizational thinking
    a. Proactive, not reactive
    b. Focus on building a strong, resilient system
    c. Understand vulnerabilities
    d. Recognize bias
    e. Efficient resource management
    f. Evaluate system based on risk, not rules
6. Emphasis on achieving highly reliable health care through the following:
    a. A commitment to the goal of zero harm
    b. A safety culture, which ensures employees are comfortable reporting errors without fear of retaliation
    c. Incorporate highly effective process improvement tools and methodologies into our work flows
    d. Ensure that everyone is accountable for safety, quality, and patient experience
7. ~~Support Patient and Family Centered Care and the Patient and Family Advisory Council~~
    ~~a. Dignity and Respect: Health care practitioners listen to and honor patient~~

~~and family perspectives and choices. Patient and family knowledge, values, beliefs and cultural backgrounds are incorporated into the planning and delivery of care.~~

~~b. Information Sharing: Health care practitioners communicate and share complete and unbiased information with patients and families in ways that are affirming and useful. Patients and families receive timely, complete and accurate information in order to effectively participate in care and decision-making.~~

~~c. Participation: Patients and families are encouraged and supported in participating in care and decision-making at the level they choose.~~

~~d. Collaboration: Patients, families, health care practitioners, and health care leaders collaborate in policy and program development, implementation and evaluation; in research; in facility design; and in professional education, as well as in the delivery of care.~~

8. ~~Promote lean principles to improve processes, reduce waste, and eliminate inefficiencies~~
9. Integrate Patient and Family Centered Care principles to promote dignity, transparent communication, meaningful participation, and collaborative decision-making. Through engagement of patients, families, and the Patient and Family Advisory Council, the health system enhances care quality, safety, access, and the overall patient experience.
10. Identify areas for system improvement based on patient, family, and community input
11. Implement system-wide changes in strategy, structure, processes, culture, and leadership to adapt to external drivers such as market demands, technology advancements, and public health emergencies. Identified initiatives focus on improving employee engagement, performance, and innovation through structured change management, strong leadership alignment, and HR-supported transition planning to ensure sustainable, organization-wide improvement.
12. Utilize improvement science principles to streamline work-flows, reduce waste, improve efficiency, and enhance patient-centered care through continuous performance improvement.
13. Maximize Epic reporting functionality to ~~improve~~enhance data capture ~~and identification of areas for~~, strengthen clinical and operational visibility, and more effectively identify opportunities for quality improvement.
14. ~~Develop an enterprise wide data governance strategy~~Develop an enterprise-wide data clinical governance, and Business Intelligence strategy to ensure consistent data standards, improve data quality, support regulatory compliance, and strengthen organizational decision-making.

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

ORGANIZATION FRAMEWORK

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

Governing Board

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

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

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

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

D. The Board:

    1. Delegates the authority for developing, implementing, and maintaining performance improvement activities to Administration, Medical Staff, Management, and employees;
    2. Responsible for determining, implementing, and monitoring policies governing the Critical Access Hospital (CAH) and Rural Health Clinic (RHC) total operation and for ensuring that those policies are administered so as to provide quality health care in a safe environment (CMS 485.627(a))
    3. Recognizes that performance improvement is a continuous, never-ending process, and therefore they will provide the necessary resources to carry out this philosophy;
    4. Provides direction for the organization's improvement activities through the development of strategic initiatives;
    5. Evaluates the organization's effectiveness in improving quality through reports from Administration, Department Directors, Medical Executive Committee, and Medical Staff Quality Committee.

Administrative Council

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

B. Administrative Council ensures that clinical contracts contain quality performance indicators to measure the level of care and service provided.

C. Administrative Council has developed a culture of safety by embracing High Reliability tenets and has set behavior expectations for providing Safe, Timely, Effective, Efficient, Equitable, Patient Centered Care (STEEEP™), supporting Triple Aim, and ensures compliance with regulatory, statutory, and contractual requirements.

Board Quality Committee

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

Medical Executive Committee

A. The Medical Executive Committee shares responsibility with the BOD Quality Committee, and the Administrative Council, for the ongoing quality of care and services provided within the Health System.

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

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

Department Chairs of the Medical Staff

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

Medical Staff

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

Hospital Management (Directors, Managers, and Supervisors)

A. Management is responsible for ongoing performance improvement activities in their departments and for supporting teams chartered by the Medical Staff Quality Committee. Many of these activities will interface with other departments and the Medical Staff. They are expected to do the following:
    1. Foster an environment of collaboration and open communication with both internal and external customers;
    2. Participate and guide staff to focus on patient safety, patient and family centered care, service recovery, and patient satisfaction;
    3. Advance the philosophy of High Reliability within their departments;
    4. Utilize Lean principles and DMAIC (Define, Measure, Analyze, Improve, Control) process improvement activities for department-specific performance improvement initiatives;

5. Establish performance and patient safety improvement activities in conjunction with other departments;
6. Encourage staff to report any and all reportable events including "near-misses";
7. Participate in the investigation and determination of the causes that underlie a "near-miss" / Sentinel/Adverse Event/Error or Unanticipated Outcome and implement changes to reduce the probability of such events in the future.

Employees

A. The role of the individual employee is critical to the success of a performance improvement initiative. Quality is everyone's responsibility and each employee is charged with practicing, and supporting, the *Code of Conduct* (ACMP-1901), and *Chain of Command for Medical Plan of Care* (ANS-1404) policies. All employees must feel empowered to report, correct, and prevent problems.

B. The multidisciplinary Patient Safety Committee consists of staff from each service area. This Committee will assist with quality, patient safety, patient experience, and infection prevention. They will evaluate processes, provide recommendations, identify process improvement opportunities, and communicate their findings with peers to improve practice across the Health System.

C. The multidisciplinary Patient Experience Committee consists of staff from each service area. The Committee will assist with patient satisfaction, and service excellence. They will evaluate processes, provide recommendations, identify process improvement opportunities, and communicate their findings with peers to improve service excellence across the Health System.

D. Employees are expected to do the following:
    1. Contribute to improvement efforts, including reporting Sentinel/Adverse Event/Error or Unanticipated Outcomes, to produce positive outcomes for the patient and ensure the perfect care experience for patients and customers;
    2. Make suggestions/recommendations for opportunities of improvement or for a cross-functional team, including risk reduction recommendations and suggestions for improving patient safety, by contacting their Director or Manager, the Director of Quality and Regulations, the Medical Director of Quality, or an Administrative Council Member.

PERFORMANCE IMPROVEMENT STRUCTURE

Medical Staff Quality Assessment Committee

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

are held at least quarterly each year.

The Medical Staff Quality Assessment Committee:

A. Annually review and approve the *Quality Assurance Performance Improvement Plan* (AQPI-05), *Medication Error Reduction Plan* (APH-34), *Medication Error Reporting* (APH-24), *Infection Control Plan* (AIPC-64), *Environment of Care Management Program* (AEOC-98), *Emergency Operations Plan* (AEOC-17), *Utilization Review Plan* (DCM-1701), *Discharge Plan* (ANS-238), *Risk Management Patient Safety Plan* (AQPI-04), *Employee Health Plan* (DEH-39), *Trauma Performance Improvement Plan*, *Home Health Quality Plan* (DHH-1802), and the *Hospice Quality Plan* (DHOS-1801).

B. Regularly reviews progress to the aforementioned plans;

C. Reviews quality indicator reports to evaluate patient care, and the delivery of services, and takes appropriate actions based on patient and process outcomes;

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

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

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

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

H. Reviews summaries and recommendations of Event Analysis/Root Cause Analysis (RCA) and Failure Mode Effects Analysis (FMEA) activities;

I. Oversees the radiation safety program, including nuclear medicine and radiation oncology, and evaluates the services provided and makes recommendations to the MEC;

J. Oversees the Infection Control, Pharmacy & Therapeutics, and Antibiotic Stewardship program and monitors compliance with their respective plans;

K. Oversees the multidisciplinary Cancer Committee and monitors compliance with the Cancer Center quality plan;

L. Oversees the Trauma Program and monitors compliance with the Trauma Performance Improvement plan~~.~~;

M. Oversees the Stroke Program and monitors compliance with the Stroke QA/PI plan;

N. Oversees the Interdisciplinary Practice Committee (AQPI-2401) and RN standardized procedure approvals.

Performance Improvement Committee (PIC)

A. Medical Staff Quality Assessment Committee provides direct oversight for the PIC. PIC is an executive committee with departmental representatives within the Tahoe Forest Health

System, presenting their QA/PI findings as assigned. The goal of this committee is to achieve optimal patient outcomes by making sure that all staff participate in performance improvement activities. Departmental Directors, or their designee, review assigned quality metrics annually at the PIC (See Attachment C – QA PI Reporting Measures). Performance improvement includes collecting data, analyzing the data, and taking action to improve. Director of Quality and Regulations is responsible for processes related to this Committee.

B. The Performance Improvement Committee will:
    1. Oversee the Performance Improvement activities including data collection, data analysis, improvement, and communication to stakeholders;
    2. Set performance improvement priorities that focus on high-risk, high volume, or problem prone areas;
    3. Guide the department to and/or provide the resources to achieve improvement;
    4. Reviews requests for chartered Performance Improvement Teams. Requests for teams may come from committees, department or individual employees. Not all performance improvement efforts require a chartered team;
    5. Report the committee's activities quarterly to the Medical Staff Quality Committee.

SCIENTIFIC METHOD FOR IMPROVEMENT ACTIVITIES

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

Performance Improvement Teams

A. Teams are cross-functional and multidisciplinary in nature. The priority and type of team are based on the strategic initiatives of the organization, with regard to high risk, high volume, problem prone, and low volume.

B. Performance Improvement Teams will:
    1. Follow the approved team charter as defined by the Administrative Council Members, or MS QAC
    2. Establish specific, measurable goals and monitoring for identified initiatives
    3. Utilize lean principles to improve processes, reduce waste, and eliminate inefficiencies
    4. Report their findings and recommendations to key stakeholders, PIC, and the MS QAC.

PERFORMANCE IMPROVEMENT EDUCATION

A. Training and education are essential to promote a culture of quality within the Tahoe Forest Health System. All employees and Medical Staff receive education about performance

improvement upon initial orientation. Employees and Medical Staff receive additional training on various topics related to performance improvement.

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

C. DMAIC (Define, Measure, Analyze, Improve, Control):
a. Define: identify the problem and project goals
b. Measure: collect data to understand current performance
c. Analyze: identify root causes of defects and issues
d. Improve: develop and implement solutions to address root causes
e. Control: monitor the improvement to sustain gains and ensure consistent performance

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

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

PERFORMANCE IMPROVEMENT PRIORITIES

A. The QA PI program is an ongoing, data driven program that demonstrates measurable improvement in patient health outcomes, improves patient safety by using quality indicators or performance improvement measures associated with improved health outcomes, and by the identification and reduction of medical errors.

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

1. Processes that are high risk, high volume, or problem prone areas with a focus on the incidence, prevalence, and severity of problems in those areas
2. Processes that affect health outcomes, patient safety, and quality of care
3. Processes related to patient advocacy and the perfect care experience
4. Processes related to the Critical Access Hospital (CAH) National Patient Safety Goals (NPSGs)
5. Processes related to patient flow
6. Processes associated with near miss Sentinel/Adverse Event/Error or Unanticipated Outcome

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

1. Identified needs from data collection and analysis
2. Unanticipated adverse occurrences affecting patients
3. Processes identified as error prone or high risk regarding patient safety
4. Processes identified by proactive risk assessment
5. Changing regulatory requirements
6. Significant needs of patients and/or staff
7. Changes in the environment of care
8. Changes in the community

DESIGNING NEW AND MODIFIED PROCESSES/FUNCTIONS/ SERVICES

A. Tahoe Forest Health System designs and modifies processes, functions, and services with quality in mind. When designing or modifying a new process the following steps are taken:
    1. Key individuals, who will own the process when it is completed, are assigned to a team led by the responsible individual.
    2. An external consultant is utilized to provide technical support, when needed.
    3. The design team develops or modifies the process utilizing information from the following concepts:
        a. It is consistent with our mission, vision, values, and strategic priorities and meets the needs of individual served, staff and others
        b. It is clinically sound and current
        c. Current knowledge when available and relevant, i.e., practice guidelines, successful practices, information from relevant literature and clinical standards
        d. It is consistent with sound business practices
        e. It incorporates available information and/or literature from within the organization and from other organizations about potential risks to patients, including the occurrence of sentinel/near-miss events, in order to minimize risks to patients affected by the new or redesigned process, function, or service
        f. Conducts an analysis, and/or pilot testing, to determine whether the proposed design/redesign is an improvement and implements performance improvement activities, based on this pilot
        g. Incorporates the results of:
            i. performance improvement activities
            ii. consideration of staffing effectiveness
            iii. consideration of patient safety issues
            iv. consideration of patient flow issues

4. Performance expectations are established, measured, and monitored. These measures may be developed internally or may be selected from an external system or source. The measures are selected utilizing the following criteria:
    a. identify the events it is intended to identify
    b. a documented numerator and denominator or description of the population to which it is applicable
    c. defined data elements and allowable values
    d. detect changes in performance over time
    e. allow for comparison over time within the organization and between other entities
    f. data to be collected is available
    g. results can be reported in a way that is useful to the organization and other interested stakeholders

B. An individual with the appropriate expertise within the organization is assigned the responsibility of developing the new process.

PROACTIVE RISK ASSESSMENTS

A. Risk assessments are conducted to pro-actively evaluate the impact of buildings, grounds, equipment, occupants, and internal physical systems on patient and public safety. This includes, but is not limited to, the following:
    1. A Failure Mode and Effect Analysis (FMEA) will be completed based on the organization's assessment and current trends in the health care industry, and as approved by PIC or the MS QAC.
    2. The Medical Staff Quality Committee, and other leadership committees, will recommend the processes chosen for proactive risk assessments based on literature, errors and near miss events, sentinel event alerts, and the CAH National Patient Safety Goals (NPSGs).
        a. The process is assessed to identify steps that may cause undesirable variations, or “failure modes”.
        b. For each identified failure mode, the possible effects, including the seriousness of the effects on the patient are identified and the potential breakdowns for failures will be prioritized.
        c. Potential risk points in the process will be closely analyzed, including decision points and patient’s moving from one level of care to another through the continuum of care.
        d. For the effects on the patient that are determined to be “critical”, an event analysis/root cause analysis is conducted to determine why the effect may occur.
        e. The process will then be redesigned to reduce the risk of these failure modes occurring or to protect the patient from the effects of the failure

modes.

f. The redesigned process will be tested and then implemented. Performance measurements will be developed to measure the effectiveness of the new process.

g. Strategies for maintaining the effectiveness of the redesigned process over time will be implemented.

3. Ongoing hazard surveillance rounds, including Environment of Care Rounds, and departmental safety hazard inspections, are conducted to identify any trends and to provide a comprehensive ongoing surveillance program.
4. The Environment of Care Safety Officer and EOC/Safety Committee review trends and incidents related to the Safety Management Plans. The EOC Safety Committee provides guidance to all departments regarding safety issues.
5. The Infection Preventionist, and Environment of Care Safety Officer, or designee, complete a written infection control and pre-construction risk assessment for interim life safety for new construction or renovation projects.

DATA COLLECTION

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

1. Medication therapy
2. Adverse event reports
3. National patient safety goals
4. Infection control surveillance and reporting
5. Surgical/invasive and manipulative procedures
6. Blood product usage, including transfusions and transfusion reactions
7. Data management
8. Discharge planning
9. Utilization management
10. Complaints and grievances
11. Restraints/seclusion use
12. Mortality review
13. Medical errors including medication, surgical, and diagnostic errors; equipment failures, infections, blood transfusion related injuries, and deaths due to seclusion or restraints
14. Needs, expectations, and satisfaction of individuals and organizations served, including:

a. Their specific needs and expectations
b. Their perceptions of how well the organization meets these needs and expectations
c. How the organization can improve patient safety
d. The effectiveness of pain management

15. Resuscitation and critical incident debriefings
16. Unplanned patient transfers/admissions
17. Medical record reviews
18. Performance measures from acceptable data bases/comparative reports, i.e., RL Datix Event Reporting, QCentrix, NDNQI, HCAHPS, Care Compare, QualityNet, HSAG HIIN, MBQIP, HCAI, and Press Ganey, etc.
19. Summaries of performance improvement actions and actions to reduce risks to patients

B. In addition, the following clinical and administrative data is aggregated and analyzed to support patient care and operations:
    1. Quality measures delineated in clinical contracts will be reviewed annually
    2. Pharmacy transactions as required by law and to control and account for all drugs
    3. Information about hazards and safety practices used to identify safety management issues to be addressed by the organization
    4. Records of radionucleotides and radiopharmaceuticals, including the radionucleotide's identity, the date received, method of receipt, activity, recipient's identity, date administered, and disposal
    5. Reports of required reporting to federal, state, authorities
    6. Performance measures of processes and outcomes, including measures outlined in clinical contracts

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

AGGREGATION AND ANALYSIS OF DATA

A. Tahoe Forest Health System believes that excellent data management, and analysis, are essential to an effective performance improvement initiative. Statistical tools are used to analyze and display data. These tools consist of dashboards, bar graphs, pie charts, run charts (SPC), histograms, Pareto charts, control charts, fishbone diagrams, and other tools as appropriate.

B. All performance improvement teams and activities must be data driven and outcome based. The analysis includes comparing data within our organization, with other comparable organizations, with published regulatory standards and benchmarks, and best practices. Data is aggregated and analyzed within a time frame appropriate to the process or area of study. Data will also be analyzed to identify system changes that will help improve patient safety and

promote a perfect care experience (See Attachment D for QI PI Indicator definitions).

C. The data is used to monitor the effectiveness and safety of services, and quality of care. The data analysis identifies opportunities for process improvement, and changes in patient care processes. Adverse patient events are analyzed to identify the cause, implement process improvement and preventative strategies, and ensure that improvements are sustained over time.

D. Data is analyzed in many ways including:
    1. Using appropriate performance improvement problem solving tools
    2. Making internal comparisons of the performance of processes and outcomes over time
    3. Comparing performance data about the processes with information from up-to-date sources
    4. Comparing performance data about the processes and outcomes to other hospitals, benchmarks, and reference databases

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

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

REPORTING

A. Results of the outcomes of performance improvement and patient safety activities identified through data collection and analysis, performed by Medical Staff, ancillary, and nursing services, in addition to outcomes of performance improvement teams, will be reported to the MS QAC at a minumum of annually.

B. Results of the appraisal of performance measures outlined in clinical contracts will be reported to the MS QAC at a minimum of annually.

C. The MS QAC will provide their analysis of the quality of patient care and services to the Medical Executive Committee regularly.

D. The Medical Executive Committee, Quality Medical Director, or the Director of Quality & Regulations will report to the BOD regularly relevant findings from all performance improvement activities performed throughout the System.

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

CONFIDENTIALITY AND CONFLICT OF INTEREST

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

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

ANNUAL ASSESSMENT

A. The Critical Access Hospital (CAH), and Rural Health Clinic (RHC), Quality Assessment Performance Improvement (QA PI) program, and the objective, structure, methodologies, and results of performance improvement activities will be evaluated at least annually (CMS485.641(b)(1)).

B. The evaluation includes a review of patient care and patient related services, infection control, medication administration, medical care, and the Medical Staff. More specifically, the evaluation includes a review of the utilization of services (including at least the number of patients served and volume of services), chart review (a representative sample of both active and closed clinical records), and the Health System policies addressing provision of services. Refer to *Available CAH Services* (AGOV-06) policy.

C. The purpose of the evaluation is to determine whether the utilization of services is appropriate, policies are followed, and needed changes are identified. The findings of the evaluation and corrective actions, if necessary, are reviewed. The Quality Assessment program evaluates the quality and appropriateness of diagnoses, treatments furnished, and treatment outcomes.

D. An annual report summarizing the improvement activities, and the assessment, will be submitted to the Medical Staff Quality Committee, the Medical Executive Committee, and the Board of Directors.

PLAN APPROVAL

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

Related Policies/Forms:

Available CAH Services, TFH & IVCH, AGOV-06

Medication Error Reduction Plan, APH-34

Medication Error Reporting, APH-24

Infection Control Plan, AIPC-64

Environment of Care Management Program, AEOC-908

Utilization Review Plan (UR), DCM-1701

Risk Management and Patient Safety Plan, AQPI-02

Emergency Operations Plan (Comprehensive), AEOC-17

Discharge Planning, ANS-238

Employee Health Plan, DEH-39

Quality Assurance and Performance Improvement Program, DHH-1802

Quality Assurance and Performance Improvement Program, DHOS-1801

References:

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

Attachments

A. Quality Initiatives 2026.docx

B. QA PI Reporting Matrix 2026.xlsx

C. QI Indicator Definitions 2026.docx

D. External Reporting 2026.docx

E. Quality Reporting Programs 2026.xlsx

Approval Signatures

Step Description	Approver	Date

Status **Active** PolicyStat ID **19224111**

Origination Date	12/2005	Department	Quality Assurance / Performance Improvement - AQPI
Last Approved	11/2025		
Last Revised	11/2025	Applicabilities	System
Next Review	11/2026		

Risk and Patient Safety Plan, AQPI-02

RISK:

In order to prevent patient harm or adverse events, and to minimize the impact of any events that may occur, a Risk and Patient Safety Plan is essential to identify, evaluate, and take appropriate action to prevent unintended patient care outcomes, as well as protect the financial resources, tangible assets, personnel, and brand.

POLICY:

The Tahoe Forest Hospital District (TFHD) Board of Directors makes a commitment to provide for the safe and professional care of all patients, and also to provide for the safety of visitors, employees and health care practitioners. The commitment is made through the provision of this Patient Safety Plan that will identify, evaluate, and take appropriate action to prevent unintended patient care outcomes (adverse events), as well as protect the TFHD's financial resources, tangible assets, personnel and brand. Leadership structures and systems are established to ensure that there is organization-wide awareness of patient safety performance, direct accountability of leaders for that performance and adequate investment in performance improvement abilities, and that actions are taken to ensure safe care of every patient served.

The Tahoe Forest Hospital District endorses the the National Patient Safety Goals® for the Critical Access Hospital Program. Further, the District ascribes to the tenets and practices of the High Reliability Organization and the Just Culture programs in the investigation of near-misses, adverse events and unexpected/unintended outcomes.

A. SCOPE & APPLICABILITY

1. This is a Health System program empowered and authorized by the Board of Directors of Tahoe Forest Hospital District. Therefore, it applies to all services and sites of care provided by the organization.

B. RECITALS

1. The organization recognizes that a patient has the right to a safe environment, and strives to achieve an error-free healthcare experience. Therefore, the Health System commits to undertaking a proactive approach to the identification and mitigation of unexpected/unintended outcomes.
2. The organization also recognizes that despite best efforts, errors can occur. Therefore, it is the intent of the Health System to respond quickly, effectively and appropriately when an error does occur.
3. The organization also recognizes that the patient has the right to be informed of the results of treatments or procedures whenever those results differ significantly from anticipated results.

C. AUTHORITY & RESPONSIBILITY

1. Governing Body
    a. The Governing Body, through the approval of this document, authorizes a planned and systematic approach to preventing adverse events and implementing a proactive patient safety plan. The Governing Body delegates the implementation and oversight of this program to the Chief Executive Officer (hereinafter referred to as the "Senior Leader") and request that the Medical Staff approve the creation of a Patient Safety Committee. The Medical Staff Quality Committee will serve as the Patient Safety Committee for TFHD and the Incline Village Community Hospital (IVCH) Medical Staff Committee will serve as the Patient Safety Committee for IVCH.
2. Senior Leader
    a. The Senior Leader is responsible for assuring that this program is implemented and evaluated throughout the organization. As such, the Senior Leader will establish the structures and processes necessary to accomplish this objective. The Senior Leader delegates the day-to-day implementation and evaluation of this program to the Medical Staff Quality Committee and the Management Team.
3. Medical Staff
    a. The meetings, records, data gathered and reports generated by the Patient Safety Committee shall be protected by the peer review privilege set forth at California evidence Code Section 1157 relating to medical professional peer review and for the State of Nevada subject to the same privilege and protection from discovery as the proceedings and records described in NRS 49.265.
    b. The Patient Safety Committee shall take a coordinated and collaborative approach to improving patient safety. The Committee shall seek input from and distribute information to all departments and disciplines in establishing and assessing processes and systems that may impact patient safety in the organization. The Patient Safety Committee shall recognize and reinforce that the members of the Medical Staff are

responsible for making medical treatment recommendations for their patients.

4. Management Team
    a. The Management Team, through the Director of Quality and Regulations is responsible for the day-to-day implementation and evaluation of the processes and activities of this Risk and Patient Safety Plan.

5. Patient Safety Officer (The Patient Safety Officer's standing committee assignments, chain-of-command and reports/reporting structure are attached)
    a. The Director of Quality & Regulations or the Quality & Regulations staff designee shall be the Patient Safety Officer for the organization. The Patient Safety Officer shall be accountable directly to the Senior Leader, through the supervision of the Director of Quality and Regulations, and shall participate in the Patient Safety/Medical Staff Quality Committee.

6. Risk Manager (The Risk Manager's standing committee assignments, chain-of-command and reports/reporting structure are attached)
    a. The Risk Manager shall be accountable directly to the Senior Leader, through the supervision of the Director of Quality and Regulations, and shall be responsible for the Risk Management Program functions. The Risk Manager shall participate in the Patient Safety/Medical Staff Quality Committee.

7. Patient Safety/Medical Staff Quality Committee
    a. The Patient Safety Committee shall:
        i. Receive reports from the Director of Quality and Regulations, the Risk Manager, and/or the Patient Safety Officer
        ii. Evaluate actions of the Director of Quality and Regulations, the Risk Manager, and/or Patient Safety Officer in connection with all reports of adverse events, near misses or unexpected/ unintended outcomes alleged to have occurred
        iii. Review and evaluate the quality of measures carried out by the organization to improve the safety of patients who receive treatment in the Health System
        iv. Make recommendations to the executive committee or governing body of the Health System to reduce the number and severity of adverse events that occur
        v. Report quarterly, and as requested, to the executive committee and governing body
        vi. The Patient Safety Committee members shall include, at least, the following individuals:Director of Quality and Regulations
            a. Members of the Medical Staff
            b. One member of the nursing staff (CNO or designee)

c. Director of Pharmacy
d. Medical Director of Quality
e. Risk Manager
f. Patient Safety Officer
g. Chief Operating Officer

D. PROGRAM ELEMENTS, GOALS AND OBJECTIVES

1. Risk Detection

a. Systematically identify and mitigate patient safety risks and hazards with an integrated approach in order to continuously reduce preventable patient harm across the entire environment of care.

b. Monitor and evaluate potential risk related to patient care and patient safety and actively participate in identifying cases with potential risk.

c. Include a process for addressing racism and discrimination and its impacts on patient health and safety, including monitoring sociodemographic disparities in patient safety events and developing interventions to remedy known disparities.

2. Risk Assessment

a. The Director of Quality and Regulations will establish a proactive, systematic, organization-wide approach to developing team-based care through teamwork training, skill building, and team-led performance improvement interventions that reduce preventable harm to patients.

b. Coordinate with the support of the Risk Manager, all Risk Management activities and will provide for the flow of information among Quality Improvement, Medical Staff Services and Peer Review, Medical Staff Quality Committee and Board of Directors. The ongoing Risk Management monitoring and evaluation activities will include, but will not be limited to, the following:

i. Safety Risk Management reporting refer to policy Event Reporting, AQPI-06
ii. Customer Satisfaction
iii. Claims Litigation Data
iv. Patient Rights
a. Access to care
b. Patient complaints
c. Informed consent
d. Advance directives
v. Staff Performance
a. Medical staff

b. Non-medical staff

vi. Process of Care

vii. Outcome of Care

viii. Organizational Data

a. Utilization management

b. Management process

ix. The Director of Quality and Regulations, Risk Manager, or designees shall carefully evaluate all concerns and further investigate specific complaints when deemed appropriate. Complaints may be generated by patients, relatives, visitors, the general public, physicians, employees, and other health care organization representatives. Once a concern has been generated, it is logged into the Risk Management Department's Event Reporting System and is scheduled for further investigation as appropriate.

x. Identification of variations representing quality of care and potential liability issues shall be referred to the appropriate department/committee, Chair/Director for action when necessary using the tenets and practices of Collaborative Culture of Safety and Just Culture.

3. Risk Prevention – Findings reported through Administration, Medical Staff Committees, Patient Safety, etc., are utilized to enhance the quality of patient care, improve patient, employee, visitor, and health care practitioners' safety and to minimize risk and losses. Findings will be documented through the appropriate department/committee minutes.
4. Risk Appraisal – To determine the overall Risk Management program's effectiveness and efficiency, the program shall be internally evaluated on an annual basis with revisions made as indicated. The risk appraisal process will include an external risk assessment at least every two (2) years or as needed. Typically, the external appraisal will be conducted by the District's professional liability insurance carrier or their designee.
5. Assess patient safety risk, identify threats, prevent occurrence or mitigate frequency and severity of harm when unexpected/unintended outcomes occur.
6. Promote a safe environment in the Health Systems to alleviate injuries, damages or losses.
7. Foster communication with patients, employees, medical staff and administration when patient safety issues are identified.
8. Contribute to performance improvement activities and plans to resolve patient safety issues.
9. Participate and/or consult on all patient disclosure conferences regarding unexpected/unintended outcomes utilizing the disclosure checklist.

10. Utilize the Beta HEART (healing, empathy, accountability, resolution, trust) principles fostering a culture of safety and transparency including the following:
    a. Administration of the SCOR Culture of Safety survey and sharing of the results utilizing a debrief methodology
    b. Utilizing a formalized process for early identification and rapid response to adverse events integrating human factor/ergonomic analysis and high reliability organization principles
    c. A commitment to honest and transparent communication with patient and families after an adverse event
    d. Staff referral to the Peer Support/Care for the Caregiver program, which is available 24/7
    e. A process for early resolution when harm is deemed a result of inappropriate care or medical error
11. Event investigation includes assessing the environment and securing physical evidence, and utilizes cognitive interview skills of all staff involved and the patient/family as appropriate.
12. Designing or Re-designing Processes
    a. When a new process is designed (or an existing process is modified) the organization will use the Patient Safety Officer to obtain information from both internal and external sources on evidence-based methods for reducing medical errors, and incorporate best practices into its design or re-design strategies.
13. Identification of Potential Patient Safety Issues
    a. Incident/Occurrence Reporting – The process of reporting and review and evaluation of incidents/occurrences shall be organization-wide and performed in accordance with the established organizational policy for reporting incidents. The expectation is that events are reported as soon as possible and at a minimum within 24 hours of the occurrence. Events are reviewed and investigated under the guidance of the Risk Manager.
        i. Occurrence Screening Criteria – A clinical screening system used as a continuous monitoring tool that address quality of care, utilization, and risk issues:
            a. Identifies patient outcome/events that could potentially result in liability; immediately reviews any notice of claim, filed or threatened litigation
            b. Enables the identification of information, retrieval and early action as close to the time of the event as possible to assist the hospital and its professionals in minimizing the likelihood of a claim and financial loss, including following the District policy on disclosure of unintended outcomes or known errors; and, assisting the Medical staff with same. Refer to policy Disclosure

of Error or Unanticipated Outcome to Patients/ Families, AQPI-1909.

c. Supplements event reporting

d. Assists the hospital in determining how liability exposure can be minimized

e. Analysis of patient safety events by specified sociodemographic factors to identify disparities in the events.

f. Increases Medical Staff involvement in Risk Management activities

g. Provides a course of information for the hospital's quality review effort

b. Patient Safety Issues shall encompass the entire environment of care and shall include, but will not be limited to:

i. Preventive maintenance program

ii. External and internal disaster program

iii. Liaison with Infection Control, Quality Improvement, and Employee Health

iv. Review of policies and procedures

v. Interaction with legal counsel, insurance carriers and other regulatory agencies, as appropriate.

vi. In-service education programs

vii. Comments from Environment of Care program

14. Confidentiality

a. Any and all documents and records that are part of the internal Risk Management program as well as the proceedings, reports and records from any committee shall be confidential.

b. To protect the confidentiality of each report and subsequent reporting, the following must be adhered to:

i. Event Reports shall be maintained as confidential and should not be printed and distributed.

ii. All occurrences, when possible, should be reported to the Risk Manager within 24 hours of the incident, or discovery of the incident.

iii. All pre-electronic Quality Review Reports must be kept in accordance with the TFHD refer to policy Record Retention & Destruction ALG-1917.

iv. Access to Event Reports shall be limited to approved users with assigned privileges.

v. To maintain protective status, there must not be documentation in the medical record that an Event Report has been submitted

vi. Use only internal @tfhd.com emails for security. Add language in emails identifying the communication is sent under these protections, when appropriate. To that end, try to educate and ensure all people involved in those email communications are using TFHD email addresses, and not personal email addresses. Some suggested language for your subject lines and/or body of the email could include:

a. "Protected Peer Review Communication" (applicable generally to both California and Nevada)

b. "Patient Safety Work Product" (for non-medical staff quality reviews)

c. "Protected under Evidence Code §§ 1156 & 1157" (California only)

d. "Protected under Nevada Revised Statute § 49.119" (Nevada only)

15. Responding to Errors

a. The organization is committed to responding to known errors in care or unexpected/unintended outcomes in a manner that supports the rights of the patient, the clinical and emotional needs of the patient, protects the patient and others from any further risk, and preserves information critical to understanding the proximal and – where appropriate – root cause(s) of the error. The organization's response will include disclosure of the incident or error to the patient and/or family (as noted below in 14.a) along with care for the involved caregivers (as noted below in 12.a).

b. Errors that meet the organization's definition of a potential sentinel event will be subjected to an intensive assessment or root cause analysis using the tenets and practice of High Reliability Organizations. Management of these types of errors is described in *Sentinel/Adverse Event/Error or Unanticipated Outcome*, AQPI-1906.

16. Supporting Staff Involved in Errors

a. Following serious unintentional harm due to systems failures and/or errors that result from human performance failures, the involved caregivers shall receive timely and systematic care which may include: supportive medical/psychological care, treatment that is compassionate, just and respectful and involved staff shall have the opportunity to fully participate in the event investigation, risk identification and mitigation activities that will prevent future events. To that end, the organization has defined processes to provide care for the caregivers: (*Peer Support (Care for the Caregiver*), AGOV-1602)

17. Educating the Patient on Error Prevention

a. The organization recognizes that the patient is an integral part of the healthcare team. Therefore, patients will be educated about their role and responsibility in preventing medical errors.

18. Informing the Patient of Errors in Care
    a. The organization recognizes that a patient has the right to be informed of results of care that differ significantly from that which was anticipated, known errors and unintended outcomes. Following unanticipated outcomes, including those that are clearly caused by systems failures, the patient, and family as appropriate, will receive timely, transparent and clear communication concerning what is known about the adverse event. Management of disclosure to patients/families is described in the policy, *Disclosure of Error or Unanticipated Outcome to Patients/Families*, AQPI-1909.

19. Reporting of Medical Errors
    a. The organization has established mechanisms to report the occurrence of medical errors both internally and externally.
    b. Errors will be reported internally to the appropriate administrative or medical staff entity.
    c. Errors will be reported to external agencies in accordance with applicable local, state, and federal law, as well as other regulatory and accreditation requirements. For reporting process, see the Administrative policy, *Sentinel/Adverse Event/Error or Unanticipated Outcome*, AQPI-1906

20. Compliance with The Americans with Disabilities Act (ADA) (See the policy *Americans with Disabilities Act, ALG-1902)* a. Reasonable modifications: Adjusting policies and practices to meet patient needs b. Effective communication: Using clear language and accessible formats c. Accessible physical environment: Ensuring spaces and equipment are usable by everyone d. Staff Training: Education provided to staff about ~~disabilties~~disabilities and ADA rules

E. LINK WITH QUALITY ASSESSMENT/IMPROVEMENT

1. As part of its planning process, the organization regularly reviews the scope and breadth of its services. Attendant to this review is an identification of care processes that, through the occurrence of an error, would have a significant negative impact on the health and wellbeing of the patient. Areas of focus include:
    a. Processes identified through a review of the literature
    b. Issues identified during daily safety huddles.
    c. Issues or risks to the organization identified by the Reliability Management Team, a multidisciplinary team of staff and leadership members trained in the principles of High Reliability Organizations. (HRO).
    d. Processes identified through the organization's performance improvement program
    e. Processes identified through Safety Risk Management Reports (Event

Reporting, AQPI-06) and Sentinel Events (Sentinel/Adverse Event/Error or Unanticipated Outcome, AQPI-1906)

f. Processes identified as the result of findings by regulatory and/or accrediting agencies
    i. National Patient Safety Goals® Effective January 2024 for the Critical Access Hospital Program
    ii. Adverse events or potential adverse advents as described in HSC 1279.1
    iii. Health-care-associated infections (HAI) as defined in the federal CDC National Healthcare Safety Network.
    iv. TFHD specific results from the Safe and Reliable Healthcare Safety Culture Survey (SCOR - Safety, Communication, and Organizational Reliability)

g. Performance Related to Patient Safety
    i. Once potential issues have been identified, the organization will establish performance measures to address those processes that have been identified as "high risk" to patient safety. In addition, the following will be measured:
        a. The perceptions of risk to patients and suggestions for improving care.
            i. The level of staff reluctance to report errors in care and staff perceptions of the organization's culture of safety as assessed through an industry-recognized external survey.
        b. Opportunities to reduce errors that reflect system issues are addressed through the organization's performance improvement program.
        c. Opportunities to reduce errors that reflect the performance of the individual care provider are addressed, as appropriate, through the Medical Staff peer review process or through the organization's human resource policy(s) using the practices and tenets of High Reliability Organization.
        d. Ensure timely, honest, and transparent communication with the patient and family utilizing the Beta HEART principles that includes:
            i. Assuming responsibility for the event
            ii. Expressing empathy and sincerely apologizing for the event
            iii. Identifying areas for improvement

iv. Designating an organizational contact who will be responsible for ongoing empathetic and transparent communication

v. Utilizing the multidisciplinary early resolution team and the claims partners to determine fair and reasonable reparation

vi. Developing a restitution plan that includes Administration and Board of Director approval

ii. Compliance with the CMS Patient Safety Structural Measure's Five Domain Attestations Domain 1: Leadership Commitment to Eliminating Preventable Harm Domain 2: Strategic Planning & Organizational Policy Domain 3: Culture of Safety & Learning Health Systems Domain 4: Accountability & Transparency Domain 5: Patient & Family Engagement

F. EVALUATING THE EFFECTIVENESS OF THE PROGRAM

1. On an annual basis, the organization will evaluate the effectiveness of the patient safety program. A report on this evaluation will be provided to the Patient Safety/ Medical Staff Quality Committee, Medical Staff, Senior Leader(s), and to the Governing Body.
2. Beginning January 1, 2026, and biannually thereafter, the patient safety plan will be submitted to the department's licensing and certification division.

G. PRIORITIES FOR 2025

1. Complete the SCOR Culture of Safety Survey, and conduct department specific debriefings to identify survey action plans
2. Focus on organizational wide Beta HEART principle reinforcement through education, Pacesetter articles, Safety First, and electronic email reminders.
3. Utilize implemented surveillance module for case review identification for additional safety and quality opportunities.
4. Continue quarterly submission of the patient safety data to CHPSO for inclusion in reporting and benchmarking.
5. Continue with ongoing Patient Safety education through the Pacesetter Monthly Newsletter, weekly Safety Firsts, email updates, and other educational tools.
6. Achieve 5 domain Beta HEART validation in April 2025.
7. Advance High Reliability Organization (HRO) principles with a commitment to a goal of zero preventable harm, and evaluate the feasibility of achieving certification as a collaborative HRO.
8. Provide system-wide HRO education to all employees, including leader-specific training
9. Upgrade to event reporting platform in 2025

10. Promote culture of safety with Good Catch Program and Patient Safety Council initiatives.
11. Complete the Patient Safety Structural Measure's Five Domain Attestations.

Related Policies/Forms:

Sentinel/Adverse Event/Error or Unanticipated Outcome, AQPI-1906; Event Reporting, AQPI-06; Disclosure of Error or Unanticipated Outcome to Patients/Families, AQPI-1909; Peer Support (Care for the Caregiver), AGOV-1602; Critical Access Hospital: 2024 National Patient Safety Goals (effective January 1, 2024); Americans with Disabilities Act, ALG-1902

All Revision Dates

11/2025, 01/2025, 12/2024, 12/2024, 04/2024, 12/2022, 01/2022, 02/2021, 02/2020, 02/2020, 03/2019, 08/2018, 02/2017, 12/2016, 03/2014, 02/2014, 11/2013, 10/2013, 01/2012, 01/2009

Attachments

RM/PSO Standard reports and reporting

Approval Signatures

Step Description	Approver	Date
	Janet VanGelder: Director	11/2025
	Christine O'Farrell: Risk Management & Patient Safety Associate	11/2025

Tahoe Forest Hospital District (TFHD)

TRAUMA
PERFORMANCE IMPROVEMENT PLAN
AND
DATA QUALITY PLAN

Approved by: Date:

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

_____
Medical Executive Committee Representative

COMPONENTS OF PLAN	PAGE

Mission

The mission of the Tahoe Forest Hospital District (TFHD) Trauma Program is to provide high quality patient care with a focus on mountain specific injuries and facilitate optimal patient outcomes across the continuum of care. Due to our unique location and our community focus on winter and summer outdoor activities, we will specialize in providing outstanding care to our injured patient based on our data. The trauma program at Tahoe Forest Hospital will deliver care consistent with American College of Surgeons (ACS) Level 3 trauma designation standards.

Vision

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

Scope and Authority

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

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

Patient Population

The injured patient is a victim of an external cause of injury that result in major or minor tissue damage or destruction. Those with a major injury have a significant risk of adverse outcome that is influenced by the patient's age, the magnitude or severity of the anatomic injury, the

physiologic status of the patient at the time of admission to the hospital, the pre-existing medical conditions, and the external cause of injury.

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

Data Collection

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

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

Confidentiality Protection

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

Trauma Performance Improvement Process

The performance improvement process is a continuous process of monitoring, assessment, and management directed at improving care. This process includes issue identification, evaluation, recommendation, action items, and loop closure. We have site specific audit filters that are designed for our specific issues, as well as required by the American College of Surgeons. We have a process improvement dictionary that was created that defines each audit filter. These issues can be identified by the TPM or the PI nurse and sent through our review process explained below.

Primary Review

Primary review of performance issues is initiated both concurrently and retrospectively by the trauma program staff and TPM. Data abstraction and collection occur daily or while care is being delivered and Performance Improvement. Events are identified and validated. Changes in patient's plan of care or implementation of clinical guidelines may be implemented immediately. Prompt feedback to providers will occur in parallel by the TPM or TMD. Many cases that relate to nursing care and basic trauma protocols may be closed at

this level of review. Retrospective review may be necessary for events not identified during concurrent review

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

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

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

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

Secondary Review

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

Tertiary Review

Tertiary review of performance improvement events is initiated monthly at MDTPC. Events referred to MDTPC for tertiary review include:

- Events that cannot be resolved at primary or secondary review
- All Deaths
- All system issues that negatively impact patient outcome
- Selected complications
- Some specialty referral cases
- Selected Acute Transfers
- Rarely seen injuries or unexpected outcomes

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

Action Items

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

- Guideline, protocol, or pathway development or revision
- Additional and/or enhanced resources
- Individual counseling
- Case presentation
- Task force to address issue
- Targeted educational intervention

The action item is taken and implemented by the TPM and TMD and tracked by the PI nurse. These findings are reported back to the MDTPC, TOC, TMD, or TPM. At this point, the review of the particular issue is complete if the issues is resolved. If re-evaluation of the issue is needed, then a time frame is established for revisiting the issue.

Loop Closure

During review period of the action item, the PI nurse keeps the TPM and TMD up to date on outcomes on a weekly basis. The reviewed charts and action items being followed is added to monthly tracking report. We title our action items as Track and Trend issues. They are set forth to monitor our action items with specific and timely goals. These items are reported monthly to the Quality department.
Methods for loop closure include:

- Review of individual behavior after coaching/education
- Review for compliance with clinical practice guidelines set in place
- Review of event identification occurrences
- Retrospective chart review for tracked events
- Feedback to physicians, nurses, staff, patients, and families

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

Performance Improvement Indicators

Trauma performance improvement indicators, or PI filters, are used to examine the timeliness, appropriateness, and effectiveness of care provided for trauma patients. These PI filters are utilized to ensure the delivery of high-quality care to the injured patient. These indicators are monitored and altered if needed through the three established levels of review in the PIP. During review, potential care problems and areas for improvement are identified and care is measured against internal and external benchmarks. The creation of the PI dictionary was done to define each audit filter that the PI team uses.

Trauma Clinical Practice Guidelines

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

Performance Improvement Team Members and Roles

Trauma Medical Director

- Develops reviews and is accountable for all protocols, policies and procedures applicable to the trauma service.
- Develops and reviews methods and systems for gathering, analyzing and utilizing the information.
- Initiates secondary review with loop closure if applicable, recommends events for tertiary review.
- Assesses the program's effectiveness and efficiency and/or suggests to TOC modification of the system as necessary to improve program performance.
- Evaluates provider performance and performs ongoing professional practice evaluation (OPPE)
- Is responsible for the reappointment of members and addition of new physicians to the Trauma Call.
- Chairs the monthly TOC and MDTPC
- Attends and presents cases for quarterly Trauma Review Committees for Sierra-Sacramento Emergency Medical Services.
- Attends and presents cases for the quarterly quaternary case review meeting through our local level 2 trauma center, Renown Regional

Trauma Program Manager

- Coordinate management across the continuum of trauma care, which includes the planning and implementation of clinical protocols and practice management guidelines, monitoring care of inpatient hospital patients, and serving as a resource for clinical practice.
- Provide for intra-facility and regional professional staff development, participate in case review, implement practice guidelines, and direct community trauma education and injury prevention programs.
- Monitor clinical processes, outcomes and system issues related to the quality of care provided; develop quality filters, audits, and case reviews; identify trends and sentinel events; and help outline remedial actions while maintaining confidentiality.
- Supervise collection, coding, scoring, and developing process for validation of data. Design the registry to facilitate performance improvement activities, trend reports, and research while protecting confidentiality.
- Participate in the development of trauma care systems at the community, state, provincial, or level.
- Responds to trauma team activations that occur during work hours; functions in whatever role necessary to assist the team in the care of the injured patient.
- Collaborates with trauma program medical director, physicians and other health care team members to provide clinical and system oversight for the care of the trauma patient.
- Oversee the PI nurse and delegate tasks for action item loop closure.

PI Nurse

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

Registrars (vetted third party vendor Q-Centrix)

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

Trauma Surgeons and Sub-Specialists

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

Nursing/Ancillary Departments

- Notify TMD and/or TPM of clinical and systems issues.
- Investigate selected issues involving care delivered in various nursing units.
- Participate in resolving care and systems issues as appropriate.

- Facilitate staff education as needed to support PI issue resolution and delivery of quality care.
- Attend MDTPC as necessary.

Pre-hospital Care

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

Physicians

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

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

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

Nursing

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

Physician Assistants and Nurse Practitioners

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

Performance Improvement Committees

Trauma Operations Committee

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

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

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

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

Trauma liaisons must attend at least 50% of scheduled meetings

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

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

- EMS liaisons
- Law Enforcement
- Ski Patrol
- UC referring providers

- Inpatient Managers/Nurses
- Radiology department
- Lab department
- RT department
- ER manager
- Acute care/Inpatient Director
- CNO
- CMO
- COO

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

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

Additionally, TPM and TMD participate in quarterly meetings with Renown Regional Trauma Center, a Level 2 trauma center that is our main referral institution. Selected cases are presented from its Level III and Level IV partners, focusing on opportunities for improvement from referring facilities and ensuring the the Level II is maintaining access to care. Follow-up is given including opportunities for improvement for the care at Renown as well.

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

Documentation of Findings
Each case that is reviewed at any level is documented in our review template. These are placed in a closed folder when the loop has been closed. The registry is used to support the PI process by identifying cases meeting review criteria, generating reports for performance

indicators, calculating patient volumes, trends, and occurrences, and calculating ISS, RTS and TRISS scores, and probability of survival, and participation in the State registry, NTDB, and TQIP.

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

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

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

Ongoing Program Professional Evaluation (OPPE's)
The structure and functions of the Performance Improvement Program is periodically reviewed by the TMD and TPM to assure that the program is achieving its desired objectives, and that its demonstrated impact is cost efficient and consistent with the American College of Surgeons, HFAP and other external requirements. In addition to program evaluation, OPPE's are performed yearly on the trauma surgeons.

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

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

- Patient outcome
- Co-morbid conditions
- TQIP process measures

Data Validation and Inter-Rater Reliability

First line data validity is assessed by the registrar by utilizing the validator tool in the NQS program. If issues are identified at this level, they are corrected by registrar. The registrars perform Interrater reliability (IRR) score on each other's charts for 5% of the charts entered for a month. Additionally, the TPM is responsible for a chart review of 10% of charts abstracted by the registrar utilizing the TFH registry IRR. The goal is 97% accuracy. Results are reported bay to registry staff during monthly meetings.

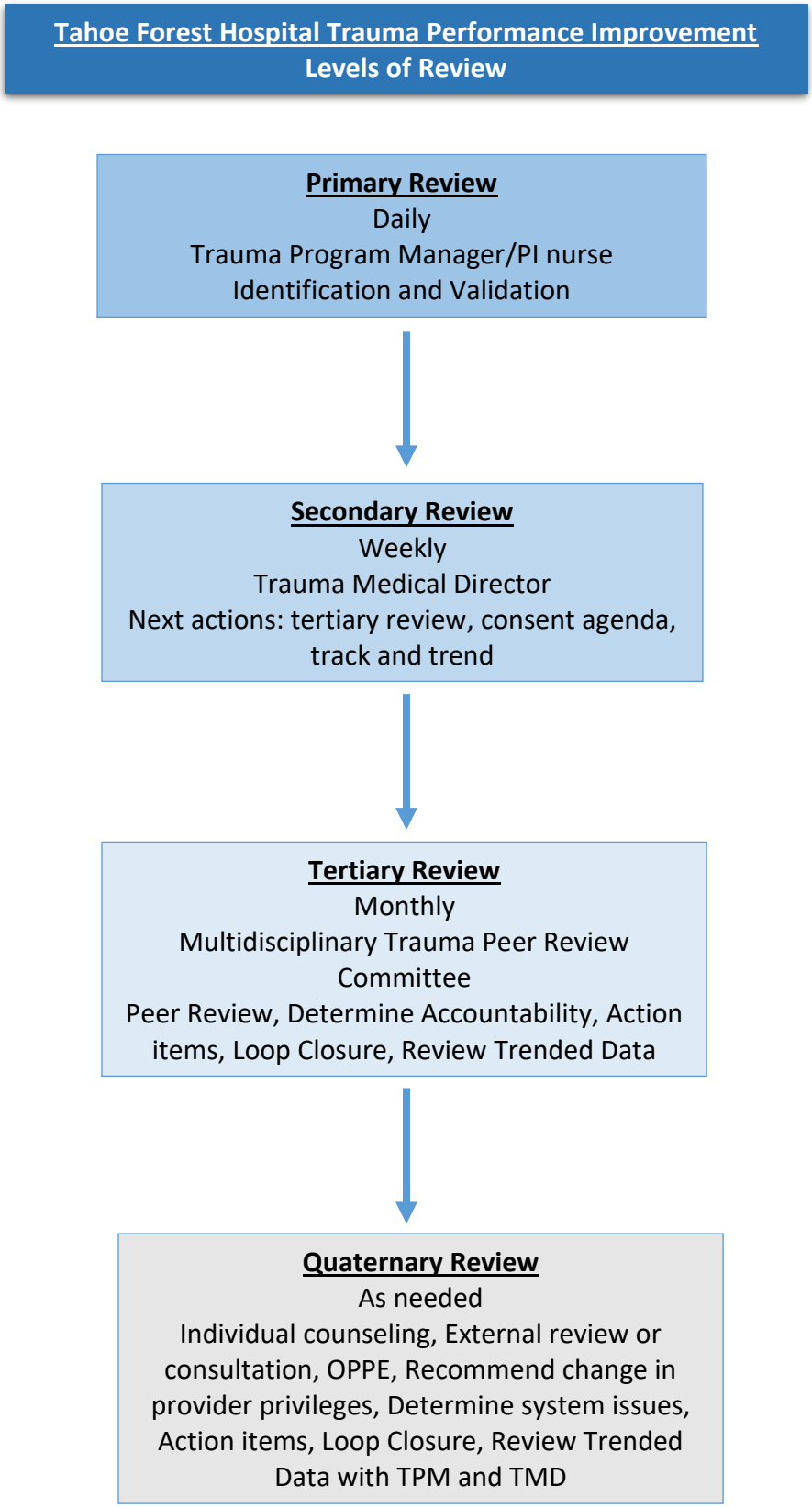
If issues are identified at TFH chart review level, the registrar and Q-Centrix team lead work together to correct issues identified and provide feedback on any data abstraction challenges.

TQIP validation reports are run with each quarterly submission and are reviewed for data completeness and mapping issues. Any issues identified are addressed and the data is resubmitted. The TPM and Q-Centrix meet on a monthly basis to discuss data validity issues, mapping issues, and abstraction challenges. Data validity trends if identified by TPM and Q-Centrix team lead are then discussed with TMD and can be forwarded to MDTPC for review.

Data Utilization

The data entered into our registry is utilized in many different ways. Reports in NQS are utilized monthly to trend and present required metrics to our Trauma Operations Committee. Reports are also utilized to pull specific patient populations, injury patterns, follow up for pre-hospital, and uses for injury prevention.

We are benchmarked against other level III hospitals across the country on our quarterly TQIP reports. These reports are utilized to drill down and understand if we are having a system issue and create PIPS plan.


Tahoe Forest Hospital Trauma Performance Improvement
Levels of Review
Primary Review
Daily
Trauma Program Manager/PI nurse
Identification and Validation
Secondary Review
Weekly
Trauma Medical Director
Next actions: tertiary review, consent agenda, track and trend
Tertiary Review
Monthly
Multidisciplinary Trauma Peer Review Committee
Peer Review, Determine Accountability, Action items, Loop Closure, Review Trended Data
Quaternary Review
As needed
Individual counseling, External review or consultation, OPPE, Recommend change in provider privileges, Determine system issues, Action items, Loop Closure, Review Trended Data with TPM and TMD

Addendum

Changes to PI and Data Plan

Date	Changes
7.31.20	Fine-tuned revised PI process and algorithm
01/2023	Revised PI process due to adding a PI nurse and integrated a Data Quality plan
11/24/25	Updated names (TPM and CNO), and updated name of registry system

Status **Active** PolicyStat ID **19771518**

Origination Date	03/2013
Last Approved	01/2026
Last Revised	01/2026
Next Review	01/2027
Department	Case Management - DCM
Applicabilities	System

Utilization Review Plan(UR), DCM-1701

RISK:

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

POLICY:

A. Under this Plan, Tahoe Forest Hospital District

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

resources

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

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

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

ii. Medical necessity of resource utilization

iii. Cost effectiveness

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

v. Fulfills hospital and medical staff Utilization Review obligations

5. Utilization Review/Case Management Staff

    a. Delegation for utilization process related duties as defined in this plan, in departmental policies and procedures and in respective position descriptions.

E. Utilization Review Committee(UR) functions

1. The Utilization Management components of the Committee include the following duties and functions:

    a. To maintain an ongoing Utilization Management Program in compliance with applicable regulations and special UR or contract care arrangements.

    b. To establish and maintain a criterion-based system for the concurrent monitoring of appropriateness of level of care and the use of hospital resources and services.

    c. Oversight of UM Physician Advisor (PA) services

    d. To evaluate information generated through the Utilization Management Program and, where appropriate, to recommend action to correct patterns of over-, under- or otherwise inappropriate resource utilization.

    e. To monitor the effectiveness of actions taken to improve efficiency or resolve problems.

    f. To review cases of payment denials and determine whether reconsideration through appeal process should be undertaken or supported by the hospital.

    g. To make recommendations as determined appropriate for focused review activity in admission planning, concurrent review and ancillary service utilization monitoring.

    h. To coordinate the Utilization Management Program with other Medical and Hospital committees

    i. To develop program goals and objectives defining program accountability for impacting the Hospital's delivery of quality, cost effective health care.

    j. To provide input into administration on resource utilization and UR aspects of proposals and plans for contracting delivery of care on preferred provider or other special contact basis

    k. To perform an annual review of the effectiveness and functioning of the UM program, and to make recommendations as indicated on program scope, organization, procedures, criteria and screening tools.

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

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

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

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

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

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

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

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

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

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

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

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

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

3. Denials / Appeals

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

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

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

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

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

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

Advisor for secondary review.

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

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

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

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

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

All Revision Dates

01/2026, 02/2023, 12/2019, 10/2019, 03/2019, 02/2019, 04/2018, 03/2017, 01/2016, 03/2015, 02/2014, 03/2013, 12/2008

Attachments

Extended Stay Review Form.docx

Approval Signatures

Step Description	Approver	Date
	Jan Iida: CNO	01/2026
	Lori Graham: Mgr Case Management	01/2026

Status **Draft** PolicyStat ID **19407774**

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

Available CAH Services, TFH & IVCH, AGOV-06

RISK:

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

POLICY:

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

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

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

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

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

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

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

TAHOE FOREST HOSPITAL DISTRICT

A. The following services are available directly at Tahoe Forest Hospital:

1. Emergency Services
2. Inpatient Medical Surgical Care
    a. Medical Surgical Pediatric care
3. Intensive Care and Step Down
    a. Step Down Pediatric care (age 7-17)
4. Swing Program
5. Obstetrical Services
6. Inpatient and Outpatient Surgery
7. Outpatient Observation Care
8. Inpatient and Outpatient Pharmacy Service
9. Medical Nutritional / Dietary Service
10. Respiratory Therapy Services
11. Rehabilitation Services that includes Physical, Occupational,~~and~~ Speech Therapy, and Wound Care
12. Inpatient and Outpatient Laboratory Services, including blood transfusion
13. Diagnostic Imaging Services that includes: PET CT, Radiation, CT Scan, MRI, Mammography, Ultrasound, Fluoroscopy, Bone Density Scan (DEXA), and Nuclear Medicine
14. Cancer Center, including Outpatient and Inpatient infusion therapy, and Radiation Oncology Center
15. Home Health
16. Hospice
17. Palliative Care
18. Skilled Nursing Care
19. Outpatient Services that includes Wellness ~~program~~Programs, Cardiac & Pulmonary Rehabilitation, Occupational Health Services, Multispecialty Clinics, Rural Health ~~Clinic~~Clinics including Behavioral Health and Addiction Medicine Clinics, and Audiology

20. ~~Medical and Radiation Oncology Services~~Urgent Care Services

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

C. Telemedicine Agreements at Tahoe Forest Hospital:
    1. Psychiatric Telemedicine Services (CEP-America Psychiatry PC d/b/a Vituity)
    2. Tele-Stroke and Emergent Tele-Neurology Services (Telespecialists, LLC)

3. Oncology Telemedicine Services (UC Davis)
4. Neonatal & Pediatric ICU Telemedicine Services (UC Davis)
5. Anthem Blue Cross of California
6. Alina Telehealth
7. Plumas District Hospital
8. Barton Memorial Hospital

D. The following services are provided to patients by Agreement or Arrangement at Tahoe Forest Hospital:
    1. Emergency Professional Services
    2. On Call Physician Program
    3. Hospitalist Services
    4. Pathology and Laboratory Professional Services
    5. Blood and Blood Products Provider: United Blood Services Reno, NV
    6. Diagnostic Imaging Professional Services
    7. Anesthesia Services
    8. Pharmacy Services
    9. Telehealth Services
    10. Tissue Donor Services
    11. Biomedical Services
    12. Interpreter Services
    13. Audiology Services
    14. Dosimetry and Physics Services

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

and Speech Therapy

F. Transfer Agreements at Incline Village Community Hospital provide other needed services as outlined in the Transfer Agreements:
    1. Renown Regional Medical Center (Reno, NV)
    2. Saint Mary's Regional Medical Center (Reno, NV)
    3. Carson Tahoe Hospital (Carson City, NV)
    4. Carson Valley Medical Center (Gardnerville, NV)
    5. Tahoe Forest Hospital (Truckee, CA)
    6. Barton Healthcare System (South Lake Tahoe, CA)
    7. Northern Nevada Medical Center (Sparks, NV)
    8. Northern Nevada Sierra Medical Center (Reno, NV)
    9. Hearthstone of Northern Nevada (Sparks, NV)
    10. Banner Health
    11. Emergency Transportation Agreement with:
        a. North Lake Tahoe Fire Protection (Incline Village, NV)
        b. Careflight

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

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

12. Dosimetry and Physics Services

References:

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

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

Approval Signatures

Step Description	Approver	Date

TAHOE FOREST
HOSPITAL DISTRICT

REGULAR MEETING OF THE BOARD OF DIRECTORS
DRAFT MINUTES

Thursday, February 26, 2026 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 4:02 p.m.

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

Board Member Absent: none

Staff in attendance: Anna Roth, President & CEO; Brian Evans, MD, Chief Medical Officer; Crystal Felix, Chief Financial Officer; Jan Iida, Chief Nursing Officer; Janet Van Gelder, Director of Quality & Regulations; Christine O'Farrell, Risk Management, Matt Mushet, In-House Counsel; Gary Harper, Compliance Analyst & Auditor; Sarah Jackson, Clerk of the Board;

Other: David Ruderman, General Counsel; Scott Kraft, DoctorManagement, LLC and Sean Weiss, DoctorsManagemnt, LLC (zoom)

3. DELETIONS/CORRECTIONS TO THE POSTED AGENDA

4. INPUT AUDIENCE

Open Session recessed at 4:05 p.m.

5. CLOSED SESSION

5.1. Approval of Closed Session Minutes◈
5.1.1. 01/22/2026 Regular Meeting
Discussion was held on a privileged item.

5.2. Hearing (Health & Safety Code § 32155)◈
Subject Matter: Fourth Quarter CY 2025 Corporate Compliance Report
Discussion was held on a privileged item.

5.3. Hearing (Health & Safety Code § 32155)◈
Subject Matter: 2025 Annual Quality Assurance/Performance Improvement Report
Number of items: Eight (8)

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

Subject Matter: Medical Staff Credentials

Discussion was held on a privileged item.

6. DINNER BREAK

APPROXIMATELY 6:00 P.M.

7. OPEN SESSION – CALL TO ORDER

Open Session reconvened at 6:01 p.m.

8. REPORT OF ACTIONS TAKEN IN CLOSED SESSION

General Counsel reported out from Closed Session. Item 5.1. were approved on a 5-0 vote. Closed Session Items 5.2 and 5.3 were approved with a 5-0 votes. Medical Staff Credentials, item 5.4 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. ACKNOWLEDGMENTS

12.1. Tahoe Titans Youth Baseball Team

Support of local youth baseball team, the Tahoe Titans participants including their players, coaches, volunteers, and families, and their commitment to our community youth.

President & CEO provided comments to Tahoe Titans Baseball Team

COO read sponsorship letter from Tahoe Forest Health System and Tahoe Forest Health System Foundation.

Emergency Room Medical Director, Dr. Aaron Gladman provided comments.

13. PRESIDENT & CEO – MONTHLY HIGHLIGHTS

13.1. Monthly Highlights

President & CEO Anna M. Roth provided an update highlighting Health Within Reach, Peaks of Excellence, Transformation, key developments, initiatives, and recent activities impacting the District.

Behavioral Health, Crisis Response and Community Service information was shared.

Further discussion was held on the Monthly Highlights.

14. MEDICAL STAFF EXECUTIVE COMMITTEE ◈

14.1. Medical Executive Committee (MEC) Meeting Consent Agenda

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

Policies with Changes
Lab Policies
Cancer Center Policies
Standardized Procedure - Healthy Newborn Admission, DWFC-1803
Standardized Procedure - Perinatal Screening by RN, DWFC-1802

New Policy
MyChart Proxy Access for Caregivers of Patients with Diminished Capacity, AQPI-2601

Privileges with Changes
Internal Medicine
Family Medicine

Chief of Staff, Dr. Koch, provided an overview of the policy and summary of the changes.

Discussion was held.

ACTION: Motion made by Director Darzynkiewicx to approve the MEC Consent Agenda as presented, seconded by Director Chamblin.
AYES: Directors Brown, Chamblin, Darzynkiewicz, Wong, McGarry.
Abstention: None
NAYS: None
Absent: None

15. 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.

15.1. Approval of Minutes of Meetings

15.1.1. 01/22/2026 Regular Meeting

15.2. Financial Reports

15.2.1. Financial Report – January 2026

15.3. Board Reports
15.3.1. Executive Board Report – February 2026
15.4. New Policy Approval
15.4.1. Charge Capture Workflow and Reconciliation, DREV-2601
15.5. Affirm Board Committee Charters
15.5.1. Board Finance Committee Charter
15.5.2. Board Quality Committee Charter
15.6. Approve Quarterly Compliance Report
15.6.1. Fourth Quarter Corporate Compliance Report

Director Chamblin requested to pull to the CMO Board Report which is part of item 15.3.1 Executive Board Report.

ACTION: Motion made by Director Darzynkiewicz to approve the Consent Calendar with item 15.3.1. pulled, seconded by Director Brown.
AYES: Directors Brown, Chamblin, Darzynkiewicz, Wong, McGarry.
Abstention: None
NAYS: None
Absent: None

16. ITEMS FOR BOARD DISCUSSION

16.1. Semi-Annual Retirement Plan Update
The Board of Directors will receive a semi-annual retirement plan update from Multnomah Group.

Brian Montanez of Multnomah Group presented on the semi-annual retirement plan update.

Discussion was held.

16.2. Waste Audit and Assessment Report
The Board of Directors will receive an update on the Waste Audit and environmental stewardship.

Maria Paz Lopez Godoy of Waste Free Tahoe presented on the Waste Audit.

Discussion was held.

16.3. 2025 Annual Quality Report
The Board of Directors will review the 2025 Annual Quality Report.

Janet Van Gelder, Director of Quality and Regulations and Dr. Conway, Medical Director of Quality presented the 2025 Annual Quality Report.

Discussion was held.

Public Comment on the 2025 Annual Quality Report was received by Pamela Hobday.

17. TIMED ITEMS FOR BOARD ACTION

17.1. Placer County LAFCO Regular Voting Member Nomination Form

The Board of Directors will consider nominating a Director to run for the upcoming vacant Special District regular voting member seat on the Placer County LAFCO Commission.

Discussion was held.

ACTION: Motion made by Director Brown to decline to nominate a Director to run for the upcoming vacancy in the Special District seat for LAFCO, seconded by Director Wong.
AYES: Directors Brown, Chamblin, Darzynkiewicz, Wong, McGarry.
Abstention: None
NAYS: None
Absent: None

18. DISCUSSION OF CONSENT CALENDAR ITEMS PULLED, IF NECESSARY

18.1.1. Item 15.3.1. Executive Board Report – February 2026 (CMO Report)

Dr. Brian Evans, Chief Medical Officer, Kelsey McLennon, Physician Services Administrative Assistant, Sam Smith, PA-C, Administrative Medical Director, provided an update on the CMO Board Report, Executive Rounding, and Leadership Huddles.

Discussion was held.

ACTION: Motion made by Director Chamblin to approve the Executive Board Report, including the CMO Report, seconded by Director Chamblin.
AYES: Directors Brown, Chamblin, Darzynkiewicz, Wong, McGarry.
Abstention: None
NAYS: None
Absent: None

19. BOARD COMMITTEE REPORTS

Director Wong provided an update on the Board Quality Committee Meeting.

Director Darzynkiewicz provided an update on the Board Community Engagement Committee Meeting.

Director Chamblin provided an update on the IVHC Foundation Board Meeting.

20. BOARD MEMBERS' REPORTS/CLOSING REMARKS

Director Darzynkiewicz provided closing commentary on a patient publication from the community regarding HIPSEC.

Director Brown provided closing commentary regarding the recent community challenges of the community and the Health System.

21. CLOSED SESSION CONTINUED

22. OPEN SESSION

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

24. ADJOURN
Meeting adjourned at 8:11 p.m.

TAHOE FOREST
HOSPITAL DISTRICT

SPECIAL MEETING OF THE BOARD OF DIRECTORS RETREAT MINUTES

Wednesday, March 4, 2026 at 9:00 a.m. – 8:00 p.m.
Thursday, March 5, 2026 at 9:00 a.m. – 1:00 p.m.

Gravity Haus Truckee-Tahoe, 10918 Brockway Rd,
Truckee, CA 96161

Day One – Wednesday, March 4, 2026 at 9:00 a.m

1. CALL TO ORDER
Meeting was called to order at 9:00 a.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; Crystal Felix, Chief Financial Officer; Dr. Brian Evans, Chief Medical Officer; Ted Owens, Executive Director of Governance; Kim McCarl, Chief Strategy Officer; Dr. Joy Koch, Chief of Staff; Dylan Crosby, VP of Facilities & Construction; Matt Mushet, In-House Counsel, Sarah Jackson, Clerk of the Board

Other: Mark Finucane, Managing Director Alvarez & Marsal; Tere LeBarron, Executive Director Alvarez & Marsal; Keith Kelson, Senior Director Alvarez & Marsal; Larry Gage, Senior Counsel Alston & Bird; Roark Lundal, Analyst Alavarez & Marsal; Mackenzie Anderson, General Counsel;

3. AUDIENCE INPUT
None

4. ITEMS FOR BOARD DISCUSSION

4.1. Welcome and Opening Comments
Chair McGarry provided welcoming comments and group introductions were made.

CEO provided opening comments.

4.2. Retreat Agenda, Objectives and Participant Overview
Mark Finucane, Retreat Facilitator, reviewed the retreat agenda and objectives.

4.3. Review Local, Regional, and National Healthcare Landscape
Mr. Finucane reviewed regulatory and industry trends across the healthcare landscape.

Discussion was held.

Open Session Recessed at: 10:00

5. CLOSED SESSION

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

Discussion will concern: Existing and potential new programs and service lines
Estimated date of disclosure: December 2026

Discussion was held on a privileged item.

6. OPEN SESSION

Open Session Reconvened at: 12:07 p.m.

7. REPORT OUT OF CLOSED SESSION

General Counsel reported out of Closed Session. There were no reportable actions taken.

Meeting recessed for lunch at: 12:08 p.m.

LUNCH

Meeting reconvened at: 12:48 p.m.

8. ITEMS FOR BOARD DISCUSSION

8.1. Board Development Goals

The Board of Directors will discuss development of governance goals for CY 2026 and moving forward.

Mr. Gage discussed Effective Governance, powers, and duties of hospital boards.

Discussion was held.

8.2. Board Self-Assessment Tool

The Board of Directors will review the Board Self-Assessment tool.

Mr. Gage reviewed the Board Assessment process and tool.

Discussion was held.

8.3. Board Self-Assessment

The Board of Directors will review and discuss results of the Board Self-Assessment.

Mr. Gage discussed the Board Assessment results.

Discussion was held.

Open Session Recessed at: 2:35 p.m.

9. CLOSED SESSION

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

Discussion will concern: Existing and potential new programs and service lines
Estimated date of disclosure: December 2026

Discussion was held on a privileged item.

10. OPEN SESSION

Open Session Reconvened at: 4:37 p.m.

11. REPORT OUT OF CLOSED SESSION

General Counsel reported out of Closed Session. There were no reportable actions taken.

Recess / Break

Meeting recessed: 4:37 p.m. until the dinner session.

12. ITEMS FOR BOARD DISCUSSION

On site dinner session was reconvened at: 6:00 p.m.

12.1. Dinner

The Board of Directors and retreat attendees will attend dinner on site.

13. ADJOURN DAY 1

Meeting adjourned at: 8:35 p.m.

Day Two – Thursday, March 5, 2026, at 9:00 a.m.

14. CALL TO ORDER

Meeting was called to order at 9:05 a.m.

15. 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; Ted Owens, Executive Director of Governance; Kim McCarl, Chief Strategy Officer; Dr. Joy Koch, Chief of Staff; Dylan Crosby, VP of Facilities & Construction; Matt Mushet, In-House Counsel, Sarah Jackson, Clerk of the Board

Other: Mark Finucane, Managing Director Alvarez & Marsal; Tere LeBarron, Executive Director Alvarez & Marsal; Keith Kelson, Senior Director Alvarez & Marsal; Larry Gage, Senior Counsel Alston & Bird; Roark Lundal, Analyst Alavarez & Marsal; Mackenzie Anderson, General Counsel;

16. INPUT – AUDIENCE

ED Governance provided an update on the operational statistics and community update for week 1 TTHAC Truckee Navigation Center Shelter and day use center.

17. ITEMS FOR BOARD DISCUSSION

17.1. Review of Day One

Mr. Finucane and Chair McGarry reviewed day 1's agenda topics and conversations.

Discussion was held.

17.2. Retreat Agenda and Objectives

Mr. Finucane reviewed day 2's agenda and objectives.

Discussion was held.

Open Session Recessed at: 9:25 am

18. CLOSED SESSION

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

Discussion will concern: Existing and potential new programs and service lines
Estimated date of disclosure: December 2026

Discussion was held on a privileged item.

19. OPEN SESSION

Open Session Reconvened at: 12:45 p.m.

20. REPORT OUT OF CLOSED SESSION

General Counsel reported out of Closed Session. There were no reportable actions taken.

21. ITEMS FOR BOARD DISCUSSION

21.1. Closing Remarks

None

22. ADJOURN

Meeting adjourned at: 12:45 p.m.

TAHOE FOREST
HOSPITAL DISTRICT

AGENDA ITEM COVER SHEET

MEETING DATE: March 26, 2026	**ITEM:** 14.2 Financial Reports 14.2.1 Financial Report – February 2026
DEPARTMENT: Finance	**TYPE OF AGENDA ITEM:** ☐ Action ☒ Consent ☐ Discussion
RESPONSIBLE PARTY: Crystal Felix, Chief Financial 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 14.2.1 Financial Report – February 2026 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 – February 2026 from Consent agenda to allow further discussion, clarification, or commentary under Board Agenda Item 17 Discussion of Consent Calendar Items Pulled, If Necessary.

SUGGESTED MOTION/ALTERNATIVES:
Motion to accept the Financial Report – February 2026 as part of the Consent agenda.

Alternative:
If pulled from Consent agenda, provide discussion under Item 17 on the Board agenda. After discussion, request a motion to approve the Financial Report – February 2026 as presented.

LIST OF ATTACHMENTS: Financial Report – February 2026

TAHOE FOREST HOSPITAL DISTRICT
FEBRUARY 2026 FINANCIAL REPORT
INDEX

Board of Directors

Of Tahoe Forest Hospital District

FEBRUARY 2026 FINANCIAL NARRATIVE

The following is the financial narrative analyzing financial and statistical trends for the eight months ended February 28, 2026.

Activity Statistics

- TFH acute patient days were 370 for the current month compared to budget of 361. This equates to an average daily census of 13.2 compared to budget of 12.9.
- TFH Outpatient volumes were above budget in the following departments by at least 5%: Pathology, MRI, Ultrasounds, and Cat Scans.
- TFH Outpatient volumes were below budget in the following departments by at least 5%: Emergency Department visits, Home Health visits, Hospice visits, Surgery cases, Lab Send Out tests, Oncology Lab, Diagnostic Imaging, Mammography, Radiation Oncology procedures, Nuclear Medicine, Oncology Drugs Sold to Patients, Respiratory Therapy, Gastroenterology cases, and Tahoe City Physical Therapy & Occupational Therapy.

Financial Indicators

- Net Patient Revenue as a percentage of Gross Patient Revenue was 45.1% in the current month compared to budget of 46.0% and to last month's 46.6%. Year-to-Date Net Patient Revenue as a percentage of Gross Patient Revenue was 46.4% compared to budget of 45.7% and prior year's 46.6%.
- EBIDA was $1,571,792 (2.6%) for the current month compared to budget of $2,489,542 (4.0%), or $917,750 (-1.4%) below budget. Year-to-date EBIDA was $29,529,042 (5.7%) compared to budget of $21,142,885 (4.1%), or $8,386,157 (1.6%) above budget.
- Net Income was $1,574,556 for the current month compared to budget of $1,861,008 or $(286,452) below budget. Year-to-date Net Income was $27,568,057 compared to budget of $16,582,119 or $10,985,938 above budget.
- Cash Collections for the current month were $26,590,588 which is 84% of targeted Net Patient Revenue.
- EPIC Gross Accounts Receivables were $122,286,609 at the end of February compared to $123,814,594 at the end of January.

Balance Sheet

- Working Capital is at 32.7 days (policy is 30 days). Days Cash on Hand (S&P calculation) is 211.9 days. Working Capital cash increased a net $9,143,000. Increase in Cash is related to: Accounts Payable decreased $252,000, Accrued Payroll & Related Costs increased $416,000, and Capital Project and Equipment expenditures totaled $643,000. Cash Collections were below target by 16%, the District received $12,975,000 from Partnership HealthPlan and Anthem for participation in the CY24 IGT Rate Range programs and remitted $2,302,000 to the State for participation in the CY24 District Hospital Directed Payment & QIP program.
- Net Patient Accounts Receivable decreased a net $427,000. Cash collections were 84% of target. EPIC Days in A/R were 56.9 compared to 58.7 at the close of January. The Business Office, in coordination with our third-party Billing & Collection agencies, continue to clean up older, uncollectible accounts, lending to the decrease in Net Patient Accounts Receivable.
- Estimated Settlements, Medi-Cal & Medicare decreased a net $9,255,000. The District recorded its monthly estimated receivables due from the Medi-Cal Rate Range, Hospital Quality Assurance Fee, and Medi-Cal QIP programs, received $12,975,000 for participation in the CY24 IGT Rate Range program, and remitted $2,302,000 to the State for participation in the CY24 District Hospital Directed Payment & QIP program.
- Unrealized Gain/(Loss) Cash Investment Fund increased $478,000 after recording the unrealized gains in its funds held with Chandler Investments for the month of February.
- Investment in TSC, LLC decreased $61,000 after recording the estimated loss for February and trueing up the losses for January.
- Intangible Lease Asset Net of Accumulated Amortization increased a net $344,000 after recording the lease agreement for additional space for the Wound Care department.
- To comply with GASB No. 96, the District recorded Amortization Expense for February, decreasing its Right-To-Use Subscription asset $368,000.
- Accounts Payable decreased $252,000 due to the timing of the final check run in February.
- Accrued Payroll & Related Costs increased a net $416,000 due to additional accrued payroll days in February.
- To comply with GASB No. 96, the District recorded a decrease in its Right-To-Use Subscription Liability for February, decreasing the liability by $356,000.
- Estimated Settlements, Medi-Cal & Medicare increased $554,000. The District received notice from the Medicare program of overpayments on our Inpatient claims for FY26 based on our As Filed Cost Report for FY25.
- Health Insurance Plan IBNR increased $500,000 based on information received from our Third-Party Administrator.

February 2026 Financial Narrative

Operating Revenue

- Current month's Total Gross Revenue was $60,127,591 compared to budget of $61,692,193 or $1,564,602 below budget.
- Current month's Gross Inpatient Revenue was $6,707,338 compared to budget of $8,023,163 or $1,315,825 below budget.
- Current month's Gross Outpatient Revenue was $53,420,253 compared to budget of $53,669,030 or $248,777 below budget.
- Current month's Gross Revenue Mix was 40.40% Medicare, 17.33% Medi-Cal, 1.22% Other, and 41.05% Commercial Insurance compared to budget of 38.71% Medicare, 16.65% Medi-Cal, 1.20% Other, and 43.44% Commercial Insurance. Last month's mix was 40.05% Medicare, 17.56% Medi-Cal, 1.40% Other, and 40.99% Commercial Insurance. Year-to-Date Gross Revenue Mix was 42.76% Medicare, 17.00% Medi-Cal, 1.29% Other, and 38.95% Commercial Insurance compared to budget of 39.15% Medicare, 16.57% Med-Cal, 1.19% Other, and 43.09% Commercial.
- Current month's Deductions from Revenue were $33,025,140 compared to budget of $33,316,672 or $291,532 below budget. Variance is attributed to the following reasons: 1) Payor mix varied from budget with 1.69% increase in Medicare, a .67% increase to Medi-Cal, a .03% increase in Other, and Commercial Insurance was below budget 2.39%, 2) Revenues were below budget 2.50%, and 3) the District recorded $527,000 due back to the Medicare program for overpayment on FY26 Inpatient claims.

DESCRIPTION	February 2026 Actual	February 2026 Budget	Variance	BRIEF COMMENTS
Salaries & Wages	11,606,486	11,706,780	100,294	
Employee Benefits	3,695,954	3,596,053	(99,901)	Increased use of Paid Leave created a negative variance in Employee Benefits, however, lending to the positive variance in Salaries and Wages.
Benefits – Workers Compensation	84,174	90,315	6,141	
Benefits – Medical Insurance	3,082,749	3,011,858	(70,891)	The District has a self-insured plan and expense is based on actual claims paid, and an additional amount recorded for Incurred but Not Reported (IBNR) claims liability.
Medical Professional Fees	616,647	648,622	31,975	Anesthesia and Radiology Physician fees were below budget, creating a positive variance in Medical Professional Fees.
Other Professional Fees	488,720	327,361	(161,359)	Rate Range IGT consulting for Financial Administration and consulting work performed for a Physician Compensation Admin Team & Anesthesia Compensation Assessment for Multi-Specialty Clinics Administration created a negative variance in Other Professional Fees.
Supplies	4,306,376	4,943,284	636,908	Drugs Sold to Patients and Oncology Drugs Sold to Patients revenues were below budget 23.44%, creating a positive variance in Pharmacy Supplies.
Purchased Services	2,277,786	2,314,795	37,009	Outsourced laboratory testing, Wellness Bank usage, Employee Health screenings, Network Maintenance services, Community Health Index support, credit card fees, and Work Force Management/AI services were under budget, creating a positive variance in Purchased Services.
Other Expenses	1,137,936	1,171,848	33,913	We saw positive variances in Marketing, Physician Recruitment expenses, and Outside Training & Travel, creating a positive variance in Other Expenses.
Total Expenses	27,296,828	27,810,916	514,088	

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF NET POSITION
FEBRUARY 2026

	Feb-26	Jan-26	Feb-25	
ASSETS				
CURRENT ASSETS				
* CASH	$ 30,691,134	$ 21,548,308	$ 44,608,629	1
PATIENT ACCOUNTS RECEIVABLE - NET	55,973,511	56,400,406	54,410,493	2
OTHER RECEIVABLES	10,148,479	9,219,145	8,812,372	
GO BOND RECEIVABLES	472,642	8,476	479,497	
ASSETS LIMITED OR RESTRICTED	14,506,078	14,455,943	12,034,225	
INVENTORIES	7,293,435	7,324,036	5,550,648	
PREPAID EXPENSES & DEPOSITS	4,533,579	4,775,966	4,362,156	
ESTIMATED SETTLEMENTS, M-CAL & M-CARE	35,162,141	44,417,332	19,437,529	3
TOTAL CURRENT ASSETS	158,780,999	158,149,613	149,695,550	
NON CURRENT ASSETS				
ASSETS LIMITED OR RESTRICTED:				
* CASH RESERVE FUND	74,318,485	74,318,485	51,005,777	1
* CASH INVESTMENT FUND	94,096,713	93,786,993	96,683,810	1
UNREALIZED GAIN/(LOSS) CASH INVESTMENT FUND	9,716,972	9,239,115	4,602,626	4
MUNICIPAL LEASE 2025	3,418,185	3,418,185	4,593,879	
TOTAL BOND TRUSTEE 2017	23,793	23,657	22,910	
TOTAL BOND TRUSTEE 2015	838,300	750,267	1,008,392	
GO BOND TAX REVENUE FUND	3,111,952	3,107,592	2,962,827	
DIAGNOSTIC IMAGING FUND	3,700	3,700	3,658	
DONOR RESTRICTED FUND	1,202,653	1,202,653	1,194,994	
WORKERS COMPENSATION FUND	35,187	81,312	13,520	
TOTAL	186,765,939	185,931,959	162,092,393	
LESS CURRENT PORTION	(14,506,078)	(14,455,943)	(12,034,225)	
TOTAL ASSETS LIMITED OR RESTRICTED - NET	172,259,861	171,476,015	150,058,168	
NONCURRENT ASSETS AND INVESTMENTS:				
INVESTMENT IN TSC, LLC	(6,006,760)	(5,945,923)	(4,625,185)	5
PROPERTY HELD FOR FUTURE EXPANSION	1,716,972	1,716,972	1,716,972	
PROPERTY & EQUIPMENT NET	214,318,371	212,714,315	197,893,793	
GO BOND CIP, PROPERTY & EQUIPMENT NET	2,002,386	1,967,285	2,035,826	
TOTAL ASSETS	543,071,828	540,078,276	496,775,123	
DEFERRED OUTFLOW OF RESOURCES:				
DEFERRED LOSS ON DEFEASANCE	168,084	171,316	206,872	
ACCUMULATED DECREASE IN FAIR VALUE OF HEDGING DERIVATIVE	200,425	200,425	158,148	
DEFERRED OUTFLOW OF RESOURCES ON REFUNDING	3,802,255	3,825,960	4,086,711	
GO BOND DEFERRED FINANCING COSTS	370,461	372,782	398,311	
DEFERRED FINANCING COSTS	91,544	92,584	104,028	
INTANGIBLE LEASE ASSET NET OF ACCUM AMORTIZATION	13,719,210	13,375,677	10,663,444	6
RIGHT-TO-USE SUBSCRIPTION ASSET NET OF ACCUM AMORTIZATION	21,253,048	21,621,492	24,567,444	7
TOTAL DEFERRED OUTFLOW OF RESOURCES	$ 39,605,027	$ 39,660,236	$ 40,184,958	
LIABILITIES				
CURRENT LIABILITIES				
ACCOUNTS PAYABLE	12,612,639	12,865,125	$ 11,015,556	8
ACCRUED PAYROLL & RELATED COSTS	25,049,223	24,633,064	21,609,340	9
INTEREST PAYABLE	149,654	96,597	148,552	
INTEREST PAYABLE GO BOND	240,078	0	251,453	
SUBSCRIPTION LIABILITY	23,267,082	23,622,839	26,351,979	10
ESTIMATED SETTLEMENTS, M-CAL & M-CARE	3,820,356	3,265,958	6,149,062	11
HEALTH INSURANCE PLAN	4,628,800	4,128,800	3,219,201	12
WORKERS COMPENSATION PLAN	2,315,069	2,315,069	2,297,841	
COMPREHENSIVE LIABILITY INSURANCE PLAN	2,876,447	2,876,447	2,771,063	
CURRENT MATURITIES OF GO BOND DEBT	2,730,000	2,730,000	2,440,000	
CURRENT MATURITIES OF OTHER LONG TERM DEBT	5,139,974	5,139,974	4,371,046	
TOTAL CURRENT LIABILITIES	82,829,322	81,673,873	80,625,092	
NONCURRENT LIABILITIES				
OTHER LONG TERM DEBT NET OF CURRENT MATURITIES	30,499,533	30,273,239	31,005,446	
GO BOND DEBT NET OF CURRENT MATURITIES	84,479,697	84,497,653	87,715,165	
DERIVATIVE INSTRUMENT LIABILITY	200,425	200,425	158,148	
TOTAL LIABILITIES	198,008,977	196,645,189	199,503,850	
NET ASSETS				
NET INVESTMENT IN CAPITAL ASSETS	383,465,225	381,890,670	336,261,237	
RESTRICTED	1,202,653	1,202,653	1,194,994	
TOTAL NET POSITION	$ 384,667,878	$ 383,093,322	$ 337,456,230	

* Amounts included for Days Cash on Hand calculation

TAHOE FOREST HOSPITAL DISTRICT
NOTES TO STATEMENT OF NET POSITION
FEBRUARY 2026

1. Working Capital is at 32.7 days (policy is 30 days). Days Cash on Hand (S&P calculation) is 211.9 days. Working Capital cash increased a net $9,143,000. Net increase in Cash is related to: Accounts Payable decreased $252,000 (See Note 8), Accrued Payroll & Related Costs increased $416,000 (See Note 9), and Capital Project and Equipment expenditures totaled $643,000. Cash Collections were below target by 16% (See Note 2), the District received $12,975,000 from Partnership HealthPlan and Anthem for participation in the CY24 IGT Rate Range programs and remitted $2,302,000 to the State for participation in the CY24 District Hospital Directed Payment & QIP program.

2. Net Patient Accounts Receivable decreased a net $427,000. Cash collections were 84% of target. EPIC Days in A/R were 56.9 compared to 58.7 at the close of January. The Business Office, in coordination with our third-party Billing & Collection agencies, continue to clean up older, uncollectible accounts, lending to the decrease in Net Patient Accounts Receivable.

3. Estimated Settlements, Medi-Cal & Medicare decreased a net $9,255,000. The District recorded its monthly estimated receivables due from the Medi-Cal Rate Range, Hospital Quality Assurance Fee, and Medi-Cal QIP programs, received $12,975,000 for participation in the CY24 IGT Rate Range programs, and remitted $2,302,000 to the State for participation in the CY24 District Hospital Directed Payment & QIP program.

4. Unrealized Gain/(Loss) Cash Investment Fund increased $478,000 after recording the unrealized gains in its funds held with Chandler Investments for the month of February.

5. Investment in TSC, LLC decreased $61,000 after recording the estimated loss for February and trueing up the losses for January.

6. Intangible Lease Asset Net of Accumulated Amortization increased a net $344,000 after recording the lease agreement for additional space for the Wound Care department.

7. To comply with GASB No. 96, the District recorded Amortization Expense for February, decreasing its Right-To-Use Subscription asset $368,000.

8. Accounts Payable decreased $252,000 due to the timing of the final check run in February.

9. Accrued Payroll & Related Costs increased a net $416,000 due to additional accrued payroll days in February.

10. To comply with GASB No. 96, the District recorded a decrease in its Right-To-Use Subscription Liability for February, decreasing the liability by $356,000.

11. Estimated Settlements, Medi-Cal & Medicare increased $554,000. The District received notice from the Medicare program of overpayments on our Inpatient claims for FY26 based on our As Filed Cost Report for FY25.

12. Health Insurance Plan IBNR increased $500,000 based on information received from our Third Party Administrator.

Tahoe Forest Hospital District
Cash Investment
February 28, 2026

WORKING CAPITAL				
US Bank	$ 29,525,919	3.30%		
US Bank/Incline Village Thrift Store	14,640			
US Bank/Truckee Thrift Store	94,985			
US Bank/Payroll Clearing	-			
Umpqua Bank	1,055,589	1.61%		
Total			$	30,691,134
BOARD DESIGNATED FUNDS				
US Bank Savings	$ -			
Chandler Cash Portfolio Fund	250,687	3.30%		
Chandler Investment Fund	93,846,025	VAR		
Total			$	94,096,713
Building Fund	$ -			
Cash Reserve Fund	74,318,485	3.85%		
Local Agency Investment Fund			$	74,318,485
Municipal Lease 2018			$	3,418,185
Bonds Cash 2017			$	23,793
Bonds Cash 2015			$	838,300
GO Bonds Cash 2008			$	3,111,952
DX Imaging Education	$ 3,700			
Workers Comp Fund - B of A	35,187			
Insurance				
Health Insurance LAIF	-			
Comprehensive Liability Insurance LAIF	-			
Total			$	38,887
TOTAL FUNDS			$	206,537,448
RESTRICTED FUNDS				
Gift Fund				
US Bank Money Market	$ 8,389	0.09%		
Foundation Restricted Donations	27,309			
Local Agency Investment Fund	1,166,955	3.85%		
TOTAL RESTRICTED FUNDS			$	1,202,653
TOTAL ALL FUNDS			$	207,740,101

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF REVENUES, EXPENSES, AND CHANGES IN NET POSITION
FEBRUARY 2026

CURRENT MONTH ACTUAL	CURRENT MONTH BUDGET	CURRENT MONTH VAR$	CURRENT MONTH VAR%		YEAR TO DATE ACTUAL	YEAR TO DATE BUDGET	YEAR TO DATE VAR$	YEAR TO DATE VAR%		PRIOR YTD FEB 2025
				OPERATING REVENUE						
$ 60,127,591	$ 61,692,193	$ (1,564,602)	-2.5%	Total Gross Revenue	$ 518,106,196	$ 512,477,619	$ 5,628,577	1.1%	1	$ 479,311,267
				Gross Revenues - Inpatient						
$ 3,503,086	$ 3,490,190	$ 12,896	0.4%	Daily Hospital Service	$ 29,261,870	$ 27,722,875	$ 1,538,995	5.6%		$ 27,691,573
3,204,252	4,532,973	(1,328,721)	-29.3%	Ancillary Service - Inpatient	33,411,586	36,099,262	(2,687,676)	-7.4%		35,838,227
6,707,338	8,023,163	(1,315,825)	-16.4%	Total Gross Revenue - Inpatient	62,673,457	63,822,137	(1,148,680)	-1.8%	1	63,529,800
53,420,253	53,669,030	(248,777)	-0.5%	Gross Revenue - Outpatient	455,432,739	448,655,482	6,777,257	1.5%		415,781,467
53,420,253	53,669,030	(248,777)	-0.5%	Total Gross Revenue - Outpatient	455,432,739	448,655,482	6,777,257	1.5%	1	415,781,467
				Deductions from Revenue:						
32,305,468	31,138,468	(1,167,000)	-3.7%	Contractual Allowances	272,012,901	260,199,579	(11,813,322)	-4.5%	2	252,031,716
213,301	1,233,844	1,020,543	82.7%	Charity Care	2,059,002	10,249,553	8,190,551	79.9%	2	1,863,499
478,973	944,360	465,387	49.3%	Bad Debt	4,280,198	7,853,965	3,573,767	45.5%	2	3,158,124
27,398	-	(27,398)	0.0%	Prior Period Settlements	(498,296)	-	498,296	0.0%	2	(1,024,456)
33,025,140	33,316,672	291,532	0.9%	Total Deductions from Revenue	277,853,804	278,303,097	449,293	0.2%		256,028,883
74,437	112,376	37,938	33.8%	Property Tax Revenue- Wellness Neighborhood	683,659	978,177	294,518	30.1%		796,719
1,691,731	1,812,561	(120,830)	-6.7%	Other Operating Revenue	15,234,447	15,251,891	(17,444)	-0.1%	3	14,629,815
28,868,620	30,300,458	(1,431,838)	-4.7%	TOTAL OPERATING REVENUE	256,170,498	250,404,590	5,765,908	2.3%		238,708,918
				OPERATING EXPENSES						
11,606,486	11,706,780	100,294	0.9%	Salaries and Wages	98,479,739	97,047,225	(1,432,514)	-1.5%	4	88,206,094
3,695,954	3,596,053	(99,901)	-2.8%	Benefits	31,199,705	29,740,503	(1,459,202)	-4.9%	4	30,020,153
84,174	90,315	6,141	6.8%	Benefits Workers Compensation	1,078,494	722,520	(355,974)	-49.3%	4	468,364
3,082,749	3,011,858	(70,891)	-2.4%	Benefits Medical Insurance	22,449,903	24,094,864	1,644,961	6.8%	4	20,264,190
616,647	648,622	31,975	4.9%	Medical Professional Fees	4,782,361	5,104,983	322,621	6.3%	5	4,174,640
488,720	327,361	(161,359)	-49.3%	Other Professional Fees	3,044,696	3,357,188	312,492	9.3%	5	2,894,145
4,306,376	4,943,284	636,908	12.9%	Supplies	38,960,110	41,989,249	3,029,140	7.2%	6	37,163,452
2,277,786	2,314,795	37,009	1.6%	Purchased Services	17,939,915	18,059,423	119,509	0.7%	7	16,212,762
1,137,936	1,171,848	33,913	2.9%	Other	8,706,533	9,145,750	439,217	4.8%	8	8,087,456
27,296,828	27,810,916	514,088	1.8%	TOTAL OPERATING EXPENSE	226,641,456	229,261,706	2,620,250	1.1%		207,491,256
1,571,792	**2,489,542**	**(917,750)**	**-36.9%**	**NET OPERATING REVENUE (EXPENSE) EBIDA**	**29,529,042**	**21,142,885**	**8,386,157**	**39.7%**		**31,217,662**
				NON-OPERATING REVENUE/(EXPENSE)						
858,100	820,162	37,938	4.6%	District and County Taxes	6,875,849	6,482,126	393,723	6.1%	9	7,146,912
468,526	468,526	-	0.0%	District and County Taxes - GO Bond	3,748,204	3,748,204	-	0.0%		3,645,065
348,941	256,778	92,162	35.9%	Interest Income	3,243,372	2,669,557	573,815	21.5%	10	2,961,551
51,957	118,397	(66,440)	-56.1%	Donations	840,348	958,018	(117,670)	-12.3%	11	706,066
(60,836)	(151,882)	91,046	59.9%	Gain/(Loss) on Joint Investment	(596,445)	(1,215,059)	618,614	50.9%	12	(683,442)
777,655	300,000	477,655	-159.2%	Gain/(Loss) on Market Investments	3,346,297	2,400,000	946,297	-39.4%	13	3,995,633
-	-	-	0.0%	Gain/(Loss) on Disposal of Assets	20,732	-	20,732	0.0%	14	-
-	-	-	0.0%	Gain/(Loss) on Sale of Equipment	-	-	-	0.0%	15	37,450
-	-	-	100.0%	Gain/(Loss) on Split Dollar Cash Accumulation Values	-		-	100.0%	15	-
(1,988,803)	(1,995,743)	6,940	0.3%	Depreciation	(15,769,533)	(15,965,944)	196,411	1.2%	16	(14,302,540)
(204,628)	(196,624)	(8,004)	-4.1%	Interest Expense	(1,673,252)	(1,641,109)	(32,143)	-2.0%	17	(1,465,202)
(248,148)	(248,148)	0	0.0%	Interest Expense-GO Bond	(1,996,555)	(1,996,559)	4	0.0%		(2,086,347)
2,764	(628,534)	631,298	100.4%	TOTAL NON-OPERATING REVENUE/(EXPENSE)	(1,960,985)	(4,560,765)	2,599,781	57.0%		(44,854)
$ 1,574,556	**$ 1,861,008**	**$ (286,452)**	**-15.4%**	**INCREASE (DECREASE) IN NET POSITION**	**$ 27,568,057**	**$ 16,582,119**	**$ 10,985,938**	**66.3%**		**$ 31,172,808**
				NET POSITION - BEGINNING OF YEAR	**357,099,821**					
				NET POSITION - AS OF FEBRUARY 28, 2026	**$ 384,667,878**					
2.6%	**4.0%**	**-1.4%**		**RETURN ON GROSS REVENUE EBIDA**	**5.7%**	**4.1%**	**1.6%**			**6.5%**

TAHOE FOREST HOSPITAL DISTRICT
NOTES TO STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION
FEBRUARY 2026

		Variance from Budget Fav / <Unfav>	
		FEB 2026	YTD 2026
1) Gross Revenues			
Acute Patient Days were above budget 2.49% or 9 days. Swing Bed days were below budget 53.13% or 17 days.	Gross Revenue -- Inpatient	$ (1,315,825)	$ (1,148,680)
	Gross Revenue -- Outpatient	(248,777)	6,777,257
	Gross Revenue -- Total	$ (1,564,602)	$ 5,628,577
Outpatient volumes were 5% or more below in the following departments: Emergency Department visits, Home Health visits, Hospice visits, Surgery cases, Lab Send Out tests, Oncology Lab, Diagnostic Imaging, Mammography, Radiation Oncology procedures, Nuclear Medicine, Oncology Drugs Sold to Patients, Respiratory Therapy, Gastroenterology Cases, and Tahoe City Physical Therapy & Occupational Therapy.			
Outpatient volumes were above budget 5% or more in the following departments: Pathology, MRI, Ultrasounds, and Cat Scans.			
2) Total Deductions from Revenue			
The payor mix for February shows a 1.69% increase to Medicare, a .67% increase to Medi-Cal, .03% increase to Other, and a 2.39% decrease to Commercial when compared to budget. Revenues were below budget 2.50%, the Business Office continues its efforts in cleaning up older, uncollectible accounts, and the District booked $527,000 due back to the Medicare program for overpayment on FY26 Inpatient claims.	Contractual Allowances	$ (1,167,000)	$ (11,813,322)
	Charity Care	1,020,543	8,190,551
	Bad Debt	465,387	3,573,767
	Prior Period Settlements	(27,398)	498,296
	Total	$ 291,532	$ 449,293
The District booked an estimated reserve for the IVCH FY25 Medicare cost report desk audit, creating a negative variance in Prior Period Settlements.			
3) Other Operating Revenue	Community Pharmacy	$ (9,028)	$ 546,612
The revision to the FY26 HQAF and QIP budgeted receivables is creating a negative variance in Miscellaneous.	Miscellaneous	(148,063)	(700,201)
	Oncology Drug Replacement		
	Hospice Thrift Stores	6,725	21,352
The District received funding for participation in the Partnership HealthPlan Rural Provider recruitment program, creating a positive variance in Grants.	Grants	25,000	72,082
	The Center (non-therapy)	(3,156)	62,327
	IVCH ER Physician Guarantee	1,505	123,837
	Children's Center	6,187	(143,453)
	Total	$ (120,830)	$ (17,444)
4) Salaries and Wages	Total	$ 100,294	$ (1,432,514)
Employee Benefits	PL/SL	$ (222,842)	$ (1,629,972)
We saw increased use of Paid Leave in February, creating a negative variance in PL/SL. This is also lending to the positive variance in Salaries and Wages.	Other	40,119	(376,948)
	Pension/Deferred Comp	0	6
	Standby	12,015	(2,378)
Positive variance in Other is related to Employer Payroll Taxes.	Nonproductive	70,807	550,090
	Total	$ (99,901)	$ (1,459,202)
Accrued Physician Productivity Bonuses were below budget, creating a positive variance in Nonproductive.			
Employee Benefits - Workers Compensation	Total	$ 6,141	$ (355,974)
Employee Benefits - Medical Insurance	Total	$ (70,891)	$ 1,644,961
The District has a self-insured plan and expense is based on actual claims paid, plus an additional $500,000 was recorded for Incurred but Not Reported (IBNR) claims liability.			
5) Professional Fees	Multi-Specialty Clinics	$ (22,687)	$ (310,582)
Locums coverage in Urology is creating a negative variance in Multi-Specialty Clinics.	TFH Locums	(51,542)	(203,900)
	Financial Administration	(176,618)	(152,619)
Extended care hours, stroke alert monitoring, and Hospitalist Physician fees created a negative variance in TFH Locums.	Information Technology	3,333	(117,934)
	Human Resources	9,568	(112,334)
	Multi-Specialty Clinics Administration	(86,810)	(102,331)
Financial consulting services for the CY24 Voluntary Rate Range IGT program created a negative variance in Financial Administration. These services resulted in increased funds due to the District from the IGT program.	Oncology	7,539	(93)
	Corporate Compliance	-	-
	Patient Accounting/Admitting	2,000	16,000
	Medical Staff Services	(174)	24,206
Consulting work for a Physician Compensation Admin Team and Anesthesia Compensation Assessment created a negative variance in Multi-Specialty Clinics Administration.	IVCH ER Physicians	14,957	24,636
	Managed Care	4,633	32,147
	Marketing	15,438	187,857
Graphic Design consulting services were below budget, creating a positive variance in Marketing.	Administration	41,678	420,399
	Miscellaneous	109,301	929,659
	Total	$ (129,384)	$ 635,113
Strategic Planning and Environmental Assessment consulting services were below budget, creating a positive variance in Administration.			
Anesthesia and Radiology Physician Fees were below budget, creating a positive variance in Miscellaneous.			

TAHOE FOREST HOSPITAL DISTRICT
NOTES TO STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION
FEBRUARY 2026

		Variance from Budget Fav / <Unfav>	
		FEB 2026	YTD 2026
6) Supplies	Patient & Other Medical Supplies	$ (284,464)	$ (1,550,254)
Medical Supplies Sold to Patients revenues were above budget 25.95%, creating a negative variance in Patient & Other Medical Supplies.	Office Supplies	(4,403)	(9,832)
	Food	(1,706)	32,134
	Other Non-Medical Supplies	3,086	101,377
Drugs Sold to Patients and Oncology Drugs Sold to Patients revenues were below budget 23.44%, creating a positive variance in Pharmacy Supplies	Minor Equipment	34,121	183,863
	Pharmacy Supplies	890,274	4,271,851
	Total	$ 636,908	$ 3,029,139
7) Purchased Services	Patient Accounting	$ (227,464)	$ (506,170)
Outsourced billing and collection services for the Business Office created a negative variance in Patient Accounting.	Department Repairs	8,097	(88,169)
	Laboratory	13,525	(83,927)
	Pharmacy IP	(9,450)	(74,426)
Outsourced laboratory testing was below budget, creating a positive variance in Laboratory.	Human Resources	29,567	(61,405)
	The Center	(3,556)	(36,537)
	Home Health/Hospice	(1,743)	(22,469)
Wellness Bank usage and Employee Health screenings were below budget, creating a positive variance in Human Resources.	Medical Records	(4,345)	(17,015)
	Diagnostic Imaging Services - All	15,446	(7,549)
	Community Development	-	-
Radiology reads were below budget, creating a positive variance in Diagnostic Imaging - All.	Multi-Specialty Clinics	15,121	10,890
	Information Technology	23,196	57,747
Network Maintenance services were below budget, creating a positive variance in Information Technology.	Miscellaneous	178,613	948,539
	Total	$ 37,009	$ 119,509
Community Health Index support, Credit Card fees, and budgeted Work Force Management/AI services were below budget, creating a positive variance in Miscellaneous.			
8) Other Expenses	Human Resources Recruitment	$ (21,891)	$ (138,469)
Services provided to assist in recruiting key Management positions created a negative variance in Human Resources Recruitment.	Dues and Subscriptions	(12,107)	(116,426)
	Other Building Rent	(19,025)	(107,537)
	Equipment Rent	(11,805)	(46,690)
UC Davis Cancer Care Network fees along with small variances across multiple departments created a negative variance in Dues and Subscriptions.	Multi-Specialty Clinics Bldg. Rent	(4,427)	(31,448)
	Marketing	22,304	(26,560)
	Insurance	(1,060)	(19,424)
Rental rate increases for the District's employee housing units and common area maintenance services created a negative variance in Other Building Rent.	Multi-Specialty Clinics Equip Rent	(1,087)	(3,302)
	Physician Services	176	4,917
	Utilities	(44,873)	92,502
Oxygen tank rentals created a negative variance in Equipment Rent.	Miscellaneous	53,103	391,793
	Outside Training & Travel	74,605	439,862
Marketing campaigns for Orthopedics, IVCH Administration, and Website Maintenance were below budget, creating a positive variance in Marketing.	Total	$ 33,913	$ 439,217
Natural Gas/Propane costs were above budget, creating a negative variance in Utilities.			
Physician Recruitment expenses were below budget, creating a positive variance in Miscellaneous.			
9) District and County Taxes	Total	$ 37,938	$ 393,723
10) Interest Income	Total	$ 92,162	$ 573,815
11) Donations	IVCH	$ (22,401)	$ (41,000)
	Operational	(44,039)	(76,670)
	Total	$ (66,440)	$ (117,670)
12) Gain/(Loss) on Joint Investment	Total	$ 91,046	$ 618,614
The District trued up its losses in TSC, LLC for January, creating a positive variance in Gain/(Loss) on Joint Investment.			
13) Gain/(Loss) on Market Investments	Total	$ 477,655	$ 946,297
Gain on Market Investments was above budget, creating a positive variance in Gain/(Loss) on Market Investments.			
14) Gain/(Loss) on Sale or Disposal of Assets	Total	$ -	$ 20,732
15) Gain/(Loss) on Sale or Disposal of Equipment	Total	$ -	$ -
16) Depreciation Expense	Total	$ 6,940	$ 196,411
17) Interest Expense	Total	$ (8,004)	$ (32,143)

INCLINE VILLAGE COMMUNITY HOSPITAL
STATEMENT OF REVENUE AND EXPENSE
FEBRUARY 2026

CURRENT MONTH ACTUAL	CURRENT MONTH BUDGET	CURRENT MONTH VAR$	CURRENT MONTH VAR%		YEAR TO DATE ACTUAL	YEAR TO DATE BUDGET	YEAR TO DATE VAR$	YEAR TO DATE VAR%		PRIOR YTD FEB 2025
				OPERATING REVENUE						
$ 4,258,255	$ 4,180,787	$ 77,468	1.9%	Total Gross Revenue	$ 38,675,840	$ 37,257,650	$ 1,418,190	3.8%	1	$ 34,891,672
				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	-
4,258,255	4,180,787	77,468	1.9%	Gross Revenue - Outpatient	38,675,840	37,257,650	1,418,190	3.8%		34,891,672
4,258,255	4,180,787	77,468	1.9%	Total Gross Revenue - Outpatient	38,675,840	37,257,650	1,418,190	3.8%	1	34,891,672
				Deductions from Revenue:						
1,984,462	2,024,269	39,807	2.0%	Contractual Allowances	19,242,470	18,123,528	(1,118,942)	-6.2%	2	16,652,449
60,482	83,616	23,134	27.7%	Charity Care	683,324	745,153	61,829	8.3%	2	438,301
121,494	62,712	(58,783)	-93.7%	Bad Debt	824,145	558,865	(265,280)	-47.5%	2	818,578
27,398	-	(27,398)	0.0%	Prior Period Settlements	(53,794)	-	53,794	0.0%	2	(291,973)
2,193,837	2,170,597	(23,240)	-1.1%	Total Deductions from Revenue	20,696,145	19,427,545	(1,268,599)	-6.5%	2	17,617,355
51,586	50,629	957	1.9%	Other Operating Revenue	525,344	299,493	225,851	75.4%	3	387,319
2,116,004	2,060,819	55,186	2.7%	TOTAL OPERATING REVENUE	18,505,039	18,129,597	375,442	2.1%		17,661,636
				OPERATING EXPENSES						
836,980	746,107	(90,873)	-12.2%	Salaries and Wages	7,085,602	6,037,863	(1,047,739)	-17.4%	4	5,530,506
247,883	221,961	(25,922)	-11.7%	Benefits	1,798,232	1,710,783	(87,449)	-5.1%	4	1,742,127
4,119	1,957	(2,162)	-110.5%	Benefits Workers Compensation	63,612	15,656	(47,956)	-306.3%	4	10,210
183,004	178,944	(4,060)	-2.3%	Benefits Medical Insurance	1,334,876	1,431,552	96,676	6.8%	4	1,264,814
162,840	178,640	15,800	8.8%	Medical Professional Fees	1,403,737	1,429,120	25,383	1.8%	5	1,405,190
5,721	6,140	419	6.8%	Other Professional Fees	42,386	49,120	6,734	13.7%	5	19,561
235,363	118,958	(116,405)	-97.9%	Supplies	1,127,325	1,136,603	9,279	0.8%	6	987,305
101,940	106,377	4,437	4.2%	Purchased Services	851,646	856,459	4,814	0.6%	7	686,505
99,918	104,016	4,098	3.9%	Other	915,985	907,873	(8,112)	-0.9%	8	805,387
1,877,767	1,663,099	(214,668)	-12.9%	TOTAL OPERATING EXPENSE	14,623,401	13,575,030	(1,048,372)	-7.7%		12,451,605
238,237	**397,719**	**(159,482)**	**-40.1%**	**NET OPERATING REV(EXP) EBIDA**	**3,881,637**	**4,554,567**	**(672,930)**	**-14.8%**		**5,210,031**
				NON-OPERATING REVENUE/(EXPENSE)						
-	22,401	(22,401)	-100.0%	Donations-IVCH	149,055	190,055	(41,000)	-21.6%	9	20,776
-	-	-	0.0%	Gain/ (Loss) on Sale	-	-	-	0.0%	10	-
(206,191)	(207,021)	830	-0.4%	Depreciation	(1,649,532)	(1,656,172)	6,640	0.4%	11	(1,629,500)
(3,048)	(1,933)	(1,115)	57.7%	Interest Expense	(25,047)	(16,166)	(8,881)	54.9%	12	(10,048)
(209,239)	(186,553)	(22,686)	-12.2%	TOTAL NON-OPERATING REVENUE/(EXP)	(1,525,524)	(1,482,282)	(43,241)	-2.9%		(1,618,772)
$ 28,998	**$ 211,166**	**$ (182,168)**	**-86.3%**	**EXCESS REVENUE(EXPENSE)**	**$ 2,356,114**	**$ 3,072,285**	**$ (716,171)**	**-23.3%**		**$ 3,591,259**
5.6%	**9.5%**	**-3.9%**		**RETURN ON GROSS REVENUE EBIDA**	**10.0%**	**12.2%**	**-2.2%**			**14.9%**

INCLINE VILLAGE COMMUNITY HOSPITAL
NOTES TO STATEMENT OF REVENUE AND EXPENSE
FEBRUARY 2026

		Variance from Budget Fav<Unfav>	
		FEB 2026	YTD 2026
1) Gross Revenues			
Acute Patient Days were at budget at 0 days.	Gross Revenue -- Inpatient	$ -	$ -
	Gross Revenue -- Outpatient	77,468	1,418,190
Outpatient volumes were above budget in the following departments: Emergency Department visits, Laboratory tests, Lab Send Out tests, Cat Scans, Drugs Sold to Patients, Oncology Drugs Sold to Patients, Gastroenterology cases, and Physical Therapy.	Total	$ 77,468	$ 1,418,190
Outpatient volumes were below budget in the following departments: Surgery cases, EKGs, Mammography, Ultrasounds, Respiratory Therapy, Speech Therapy, and Occupational Therapy.			
2) Total Deductions from Revenue			
We saw a shift in our payor mix with a 1.22% increase in Medicare, a 1.48% decrease in Medicaid, a 1.17% decrease in Commercial insurance, and a 1.44% increase in Other. Revenues were above budget 1.9% and we saw a shift from Commercial and Medicaid to Medicare.	Contractual Allowances	$ 39,807	$ (1,118,942)
	Charity Care	23,134	61,829
	Bad Debt	(58,783)	(265,280)
	Prior Period Settlement	(27,398)	53,794
	Total	$ (23,240)	$ (1,268,599)
We booked a reserve for the FY25 Medicare cost report desk audit, creating a negative variance in Prior Period Settlements.			
3) Other Operating Revenue			
	IVCH ER Physician Guarantee	$ 1,505	$ 123,837
	Miscellaneous	(548)	102,014
	Total	$ 957	$ 225,851
4) Salaries and Wages	Total	$ (90,873)	$ (1,047,739)
Employee Benefits	PL/SL	$ (25,061)	$ (72,891)
We saw increased use of Paid Leave in February, creating a negative variance in PL/SL.	Other	(8,697)	(69,145)
	Standby	(1,053)	(15,550)
	Pension/Deferred Comp	0	0
Negative variance in Other is related to Employer Payroll Taxes.	Nonproductive	8,890	70,137
	Total	$ (25,922)	$ (87,449)
Physician Productivity bonuses were below budget, creating a positive variance in Nonproductive.			
Employee Benefits - Workers Compensation	Total	$ (2,162)	$ (47,956)
Employee Benefits - Medical Insurance	Total	$ (4,060)	$ 96,676
The District has a self-insured plan and expense is based on actual claims paid and changes to the Incurred But Not Reported liability.			
5) Professional Fees	Administration	$ -	$ -
Extended patient care hours were below budget, creating a positive variance in IVCH ER Physicians.	Multi-Specialty Clinics	-	-
	Miscellaneous	844	750
	Foundation	418	6,730
	IVCH ER Physicians	14,957	24,636
	Total	$ 16,219	$ 32,117
6) Supplies	Pharmacy Supplies	$ (121,393)	$ (62,446)
Oncology Drugs Sold to Patients volumes were above budget 136.11%, creating a negative variance in Pharmacy Supplies.	Office Supplies	(581)	(1,437)
	Food	28	1,662
	Minor Equipment	2,705	4,017
We saw a decrease in Minor Equipment purchases across most departments in February.	Non-Medical Supplies	3,546	27,681
	Patient & Other Medical Supplies	(710)	39,801
	Total	$ (116,405)	$ 9,279
Supply purchases for Facility maintenance projects were below budget, creating a positive variance in Non-Medical Supplies.			

INCLINE VILLAGE COMMUNITY HOSPITAL
NOTES TO STATEMENT OF REVENUE AND EXPENSE
FEBRUARY 2026

		Variance from Budget Fav<Unfav>	
		FEB 2026	YTD 2026
7) Purchased Services	Department Repairs	$ 5,688	$ (16,799)
We saw fewer department repairs in Surgery, Sterile Processing, Diagnostic Imaging, Ultrasound, and Plant maintenance.	Laboratory	6,410	(7,171)
	Engineering/Plant/Communications	(2,393)	(6,892)
	Pharmacy	(1,342)	(4,730)
Outsourced Laboratory testing was below budget, creating a positive variance in this category.	Multi-Specialty Clinics	(982)	(2,060)
	Miscellaneous	614	(1,906)
	EVS/Laundry	312	638
Waxing, spraying, and buffing the main floors on the first floor and Emergency Department created a negative variance in Engineering/ Plant/Communications.	Diagnostic Imaging Services - All	(77)	3,777
	Foundation	(3,793)	39,957
	Total	$ 4,437	$ 4,814
Expenses for the Incline Bowl Donor Event created a negative variance in Foundation.			
8) Other Expenses	Other Building Rent	$ (12,962)	$ (74,856)
Common Area Maintenance costs and a rental increase for an employee housing unit created a negative variance in Other Building Rent.	Miscellaneous	1,359	(26,952)
	Multi-Specialty Clinics Bldg. Rent	(1,087)	(8,961)
	Dues and Subscriptions	904	(1,472)
Oxygen tank rentals were above budget, creating a negative variance in Equipment Rent.	Insurance	650	1,515
	Equipment Rent	(2,038)	1,980
	Outside Training & Travel	3,409	26,554
Electricity and Water/Sewer costs were below budget, creating a positive variance in Utilities.	Utilities	5,156	32,912
	Marketing	8,707	41,170
	Total	$ 4,098	$ (8,112)
Marketing campaigns for the Hospital and Physical Therapy were below budget, creating a positive variance in this category.			
9) Donations	Total	$ (22,401)	$ (41,000)
10) Gain/(Loss) on Sale	Total	$ -	$ -
11) Depreciation Expense	Total	$ 830	$ 6,640
12) Interest Expense	Total	$ (1,115)	$ (8,881)

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF CASH FLOWS

	AUDITED FYE 2025		**BUDGET** FYE 2026	PROJECTED FYE 2026	ACTUAL FEB 2026	PROJECTED FEB 2026	DIFFERENCE	ACTUAL 1ST QTR	ACTUAL 2ND QTR	PROJECTED 3RD QTR	PROJECTED 4TH QTR
Net Operating Rev/(Exp) - EBIDA	51,886,266		27,556,243	35,968,163	$ 1,571,792	$ 2,489,542	$ (917,750)	$ 12,945,140	$ 9,028,708	$ 9,499,800	$ 4,494,515
Interest Income	3,958,656		3,622,400	4,529,180	114,075	250,000	(135,925)	1,076,593	1,354,051	1,192,935	905,600
Property Tax Revenue	11,279,104		11,320,000	11,762,020	9,288	-	9,288	587,757	236,387	6,437,876	4,500,000
Donations	1,193,437		5,037,312	4,952,521	249,092	118,397	130,695	60,899	563,235	369,201	3,959,185
Debt Service Payments	(3,516,862)		(3,876,518)	(3,638,463)	(235,286)	(194,155)	(41,131)	(1,484,229)	(798,504)	(773,265)	(582,465)
Property Purchase Agreement	(811,927)		(473,624)	(541,285)	(67,661)	-	(67,661)	(202,982)	(202,982)	(135,321)	-
Municipal Lease 2025	(333,643)		(1,000,932)	(1,000,930)	(83,411)	(83,411)	0	(250,232)	(250,232)	(250,232)	(250,233)
Copier	-		-	-		-	-	-	-	-	-
2017 VR Demand Bond	(795,185)		(756,793)	(767,496)	-	-	-	(672,429)	(13,058)	(82,008)	-
2015 Revenue Bond	(1,576,107)		(1,645,169)	(1,328,752)	(84,215)	(110,744)	26,529	(358,585)	(332,232)	(305,703)	(332,232)
Physician Recruitment	(121,333)		(521,000)	(304,667)	-	(33,333)	33,333	(88,000)	(83,333)	(33,334)	(100,000)
Investment in Capital											
Equipment	(4,700,844)		(5,613,300)	(8,803,517)	(632,854)	(1,130,559)	497,705	(1,247,350)	(1,713,269)	(2,493,371)	(3,349,527)
Municipal Lease Reimbursement	1,340,632		4,780,000	4,780,000	-	-	-	-	-	1,175,694	3,604,306
IT/EMR/Business Systems	-		(5,027,825)	(1,837,608)	-	(483,202)	483,202	-	-	(483,202)	(1,354,406)
Building Projects/Properties	(12,436,705)		(55,592,169)	(55,592,169)	(2,457,290)	(6,749,684)	4,292,394	(5,592,451)	(12,181,170)	(13,561,989)	(24,256,560)
Change in Accounts Receivable	(8,996,668)	N1	(328,792)	2,499,324	426,894	127,196	299,698	6,006,700	1,943,603	(3,250,630)	(2,200,349)
Change in Settlement Accounts	(10,420,429)	N2	(5,011,279)	(7,453,825)	9,809,589	8,575,501	1,234,088	(5,260,008)	(11,199,598)	7,584,278	1,421,503
Change in Other Assets	(6,444,419)	N3	(2,248,346)	(6,168,054)	248,958	(100,000)	348,958	(3,518,928)	(1,052,013)	(1,397,114)	(200,000)
Change in Other Liabilities	6,736,574	N4	(7,815,000)	(10,636,872)	348,286	1,300,000	(951,714)	(664,024)	(8,365,438)	(8,083,410)	6,476,000
Change in Cash Balance	29,757,408		(33,718,273)	(29,943,969)	9,452,545	4,169,702	5,282,843	2,822,100	(22,267,341)	(3,816,530)	(6,682,198)
Beginning Unrestricted Cash	184,297,240		214,054,647	214,054,647	189,653,786	189,653,786	-	214,054,647	216,876,748	194,609,407	190,792,877
Ending Unrestricted Cash	214,054,647		180,336,374	184,110,679	199,106,331	193,823,488	5,282,843	216,876,748	194,609,407	190,792,877	184,110,679
Operating Cash	214,054,647		180,336,374	184,110,679	199,106,331	193,823,488	5,282,843	216,876,748	194,609,407	190,792,877	184,110,679
Expense Per Day	917,777		956,582	949,491	939,567	950,217	(10,651)	936,594	937,532	939,927	949,491
Days Cash On Hand	233		189	194	212	204	8	232	208	203	194

Footnotes:

Budget - Beginning Unrestricted Cash amount for Budget FYE 2026 has been restated to match the Ending Unrestricted Cash from Audited FYE 2025.

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

TAHOE FOREST
HOSPITAL DISTRICT

AGENDA ITEM COVER SHEET

MEETING DATE: March 26, 2026	**ITEM:** 14.3. Executive Reports
DEPARTMENT: Administration	**TYPE OF AGENDA ITEM:** ☐ Action ☒ Consent ☐ Discussion
RESPONSIBLE PARTY: Administration	**SUPPORTIVE DOCUMENT ATTACHED** ☐ Agreement ☐ Presentation ☐ Resolution ☒ Other **Executive 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:
Combined monthly Board reports from Executive Leadership.

SUMMARY/OBJECTIVES:
Objective: Executive Report to review key strengths and opportunities across True North areas of priority including: Health Within Reach, Peaks of Excellence, and Transformation.

SUGGESTED DISCUSSION POINTS:

Health Within Reach – System redesign efforts focus on Third Next Available Appointment.
Transformation – Epic Optimization / Project Governance.
Peaks of Excellence / People – Executive Rounding, Recruitment of key leadership roles, regional recognition for nursing team members.
Governance & Strategic Alignment – Recent Board retreat reinforced governance

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

Alternative: pull item from consent agenda for further discussion under Item 16 on the Board Agenda. After discussion, request a motion to approve the Executive Report as presented.

LIST OF ATTACHMENTS:
Executive Board Reports – March 2026
Individual Board Reports hyperlinked in Appendix

TAHOE FOREST
HOSPITAL DISTRICT

Executive Board Report
March 2026

By:
Anna M. Roth, RN, MSN, MPH – President & CEO
Louis Ward, MHA – Chief Operating Officer
Brian Evans, MD, MBA, FACEP, CPE – Chief Medical Officer
Jan Iida, RN, MSN, CEN, CENP – Chief Nursing Officer
Kim McCarl, APR - Chief Strategy Officer
Jake Dorst, MBA – Chief Information & Innovation Officer
Dylan Crosby, MSF – Vice President of Facilities & Construction Management
Ted Owens – Executive Director Governance

Executive Summary

In March, the Board of Directors convened for a focused retreat to align on the broader forces shaping healthcare delivery and to strengthen governance as a driver of long-term performance. While no formal actions were taken, the retreat reinforced a clear direction: the challenges facing healthcare are structural and ongoing, requiring disciplined prioritization, sustained focus, and alignment across the organization.

Operational updates this month reflect both the resilience of our teams and continued forward progress across access, quality, workforce, and infrastructure. Together, these efforts position Tahoe Forest Health System to advance its True North priorities while responding to increasing complexity in the healthcare environment.

Health Within Reach

Expanding access, affordability, and connection to care

Access continues to be a central focus across the system, with multiple efforts underway to better align capacity with community need.

- Strategic redesign work in **primary care and pediatrics** is nearing completion of the initial analysis phase, with new tools in place to track access (third next available appointment) and forecast demand in real time.
- Expansion of outpatient capacity through projects such as the **North Shore Clinic, Gateway expansion, and Sierra Center** is expected to increase access by up to 12–17% in key areas.

Workforce housing remains a critical enabler of access:

- Nearly **300 employees have been supported through housing programs**, with additional placements through rental and home purchase assistance initiatives.

These efforts are essential to ensuring patients can access timely care locally while supporting workforce stability.

Peaks of Excellence

Delivering high-quality, reliable, and patient-centered care

Clinical teams continue to demonstrate strong performance and commitment to quality, even under challenging conditions.

- During significant **winter storm events**, teams maintained uninterrupted services, with staff extending shifts to ensure continuity of care.
- Preparation is underway for key **regulatory and accreditation milestones**, including Trauma Center verification and IVCH survey readiness.
- System-wide **documentation training** was completed to strengthen compliance, patient safety, and legal standards.
- New clinical capabilities, including **high-sensitivity troponin testing** at Incline Village Community Hospital, are improving early detection and diagnostic precision. Troponin testing is a new diagnostic tool that helps detect heart muscle damage earlier and more accurately. Troponin is one of the first biomarkers to rise when heart injury occurs, and this higher-sensitivity test allows clinicians to identify potential issues even sooner.

In addition, proactive planning is underway to address emerging public health risks:

- Regional **measles activity** has prompted enhanced preparedness, staff education, and community outreach. Recent cases have been identified in Sacramento, Placer, and Shasta Counties, with 26 confirmed cases statewide in the first quarter of the year.

Together, these efforts reflect a continued commitment to delivering safe, high-quality care across all settings.

People

Building a highly engaged, supported, and resilient workforce

Our people remain the foundation of our ability to deliver care, and several efforts this month reflect continued investment in engagement, leadership, and workforce stability.

- The **executive rounding initiative** is strengthening communication and feedback loops, with strong early participation and positive staff response. We're over a month into the executive rounding project and we are seeing excellent rounding numbers overall. On average, rounders are getting to about 60% of their locations which spans the entire organization.
- Recruitment of key leadership roles in **operations, community health, and home health/hospice** is enhancing system capabilities and continuity.
    - Natasha Lukasiewich, DNP, MSN, MBA, RN, joins IVCH as the new Director of Operations
    - Lauren Zeffaro, FNP-BC, ACHPN, CHCA, steps into the role of Director of Home/Health Hospice
    - Lauren Lessard, PhD, MPH, joins TFHS as Director of Community Health
- Nursing teams received regional recognition through multiple **Northern Nevada Nurses of Achievement** nominations.
    - Ellen Bjorkman - Lifetime Achievement
    - Molly Cocking - Clinical Leadership
    - Elizabeth Cooke - Emergency Nursing

At the same time, recent operational experiences underscore the importance of continued focus on workforce sustainability, including staffing models, housing, and support systems.

Transformation

Advancing innovation, infrastructure, and long-term sustainability

Transformation efforts continue across technology, infrastructure, and system design to support long-term performance.

- Ongoing **Epic optimization, AI-enabled documentation exploration, and care coordination tools** are improving clinical workflows and provider experience.
- Strengthened **cybersecurity infrastructure and system upgrades** are reducing risk and improving reliability across the organization.
- Establishment of a more formal **Project Governance process** is improving prioritization and alignment of strategic initiatives.

Infrastructure investments continue to support access and resilience:

- Progress on **seismic compliance, imaging upgrades, and facility improvements** ensures long-term safety and regulatory alignment.
- Development of a **Climate Action Plan** reflects growing commitment to environmental stewardship and community priorities.

Additionally, participation in **Nevada Rural Health Transformation initiatives** positions the system to leverage external funding for workforce, technology, and access improvements.

Governance and Strategic Alignment

The Board retreat reinforced governance as a critical foundation for achieving True North:

- Continued focus on **strategic oversight, accountability, and disciplined prioritization**
- Emphasis on **fewer, clearer priorities with stronger follow-through**
- Alignment of Board agendas with long-term strategic direction and community need

These efforts will support more consistent decision-making and strengthen alignment between governance, leadership, and operations.

Closing Perspective

This month's work reflects a clear and consistent direction: advancing access, quality, and sustainability through focus, alignment, and disciplined execution.

Our teams continue to deliver exceptional care under challenging conditions, while the organization makes meaningful progress on long-term priorities. By aligning these efforts through the True North framework, Tahoe Forest Health System is well positioned to meet the needs of our community today and into the future.

Appendix

CIIO Board Report – March 2026

CMO Board Report – March 2026

CNO Board Report – March 2026

COO Board Report – March 2026

ED Governance Board Report – March 2026

VP FM&CM Board Report – March 2026

TAHOE FOREST
HOSPITAL DISTRICT

AGENDA ITEM COVER SHEET

MEETING DATE: March 26, 2026	**ITEM:** ABD and AGOV Policies
DEPARTMENT: Administration	**TYPE OF AGENDA ITEM:** ☒ Action ☐ Consent ☐ Discussion
RESPONSIBLE PARTY: Sarah Jackson, Clerk of the Board Devon Kim, Executive Assistant	**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:
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.

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
Medical Device Tracking, AGOV-1605
Physician and Professional Services Agreements, ABD-21

Policies – Minor Changes
Plan for the Provision of Care to Patients, AGOV-26; minor edits to spelling; IVCH services updated.
Available CAH Services, TFH & IVCH, AGOV 06; edits to services and telemedicine, updated annually as part of the QAPI plan, additionally reviewed by MEC & Quality.

Policies – Major Changes
Hand-Off Communications SBAR and C-U-S Reports, AGOV-1504; updated risk assessment; updated Procedures section

SUGGESTED DISCUSSION POINTS:

These policies were reviewed on 03/11/2026 by Board Governance Committee and recommended for approval on Consent Agenda.

- Medical Device Tracking, AGOV-1605 shows References and links were verified to ensure they were correct which is why they show as "redline" or updated otherwise no changes.
- Duplicate word edited in ABD-21

SUGGESTED MOTION/ALTERNATIVES:
Move to approve the policies listed on the consent agenda as presented.

LIST OF ATTACHMENTS:
Medical Device Tracking, AGOV-1605 (redline)
Physician and Professional Services Agreements, ABD-21
Plan for the Provision of Care to Patients, AGOV-26 (redline)
Hand-Off Communications SBAR and C-U-S Reports, AGOV-1504 (redline)

Status **Draft** PolicyStat ID **20065671**

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

Plan for the Provision of Care to Patients, AGOV-26

RISK:

It is imperative to follow a framework for planning, directing, coordinating, providing, and improving health care services for our patients, and community, otherwise our patients are at risk of poor health outcomes.

PURPOSE:

The purpose this policy is to define organization-wide processes and activities that maximize the coordination and provision of care to patients at Tahoe Forest Hospital System (TFHS). The goal of the Provision of Care is to coordinate seamless services from the patients' perspective. TFHS will provide the same care to all patients and will receive the same standard of care throughout the organization. The plan describes the integrated system of settings, services, health care practitioners, and care levels that make up the continuum of care. In addition, the plan outlines organizational and functional relationships of department and committees within TFHS and how services complement one another. The Provision of Care will provide a framework for planning, directing, coordinating, providing and improving health care services in response to community, and patient needs, and improve health outcomes.

The plan serves as a basis to:

A. Identify existing and new patient care services
B. Direct and integrate patient care and support services throughout the organization
C. Implement and coordinate services among departments
D. Demonstrate improvement in the services provided
E. Direct and support comparable levels of patient care throughout the medical center
F. The Plan is a reference utilized by the organization's leadership team, staff and physicians to plan, implement, evaluate and improve services to patients and the community.

POLICY:

A. The Plan for the Provision of Care to Patients is the framework for defining patient care delivery at Tahoe Forest Hospital System. The medical staff, interdisciplinary patient care teams and organization leadership approve policies and procedures governing the provision of care. Approved hospital policies governing patient care are located in the Medical Staff Bylaws, and the Administrative, Nursing Services, Infection Control and Pharmacy manuals. Additional hospital policies governing hospital practice are found in the Surgical Services, Medical/Surgical, ICU, Diagnostic Imaging, Laboratory Services, Respiratory Therapy, Dietary, Physical, Occupational and Speech Therapies, Pharmacy, Emergency Department, Women and Family, Hospice, and Home Care manuals.

1. Tahoe Forest Hospital System provides care to patients that are appropriate, individualized and planned along a continuum of care spanning illness to wellness. Patient care is based on a multidimensional assessment of the patient's relevant physical, psychological, social, cultural and environmental status determining the patient's care needs; the hospitals capacity to meet those needs; reassessment and timely response to changing patient needs; informed decisions of providers and patients; collaboration with the continuum of care providers to meet the continuing care needs of patients, and organized to assure that care is provided in a safe and efficient manner.
2. Tahoe Forest Hospital System prohibits discrimination in all its forms on the basis of race, color, national origin, ancestry, age, disability, medical condition (limited to those conditions that are treatable within the System), and where applicable, sex, marital status, familial status, parental status, religion, sexual orientation, gender identity, gender expression, genetic information, political beliefs, educational background, economic status, reprisal, or because all or part of an individual's income is derived from any public assistance program.
3. The TFHS Plan ~~fo~~for Provision of Patient Care is consistent with the
    a. Needs of our patients and community;
    b. System's Mission, Vision, Values, and Strategic Goals and Initiatives;
    c. System's Policies and Procedures;
    d. Medical Staff Bylaws'
    e. Performance Improvement and Patient Safety Plan; and
    f. Organizational capability to provide the requisite staffing, facilities and services

B. MISSION STATEMENT

1. To strive to be the health system of choice in our region and the best mountain health system in the nation.

C. VISION STATEMENT

1. To enhance the health of our communities through excellence and compassion in all we do.

a. All members of our team, working together, will ensure that the services we provide are satisfying, effective, efficient and of the highest quality, with access for all. We will strive each day to exceed patient, community, physician and employee expectations.

2. Organizational Core Values
    a. Quality – holding ourselves to the highest standards, committing to continuous improvement, and having personal integrity in all we do.
    b. Understanding – being aware of the concerns of others, demonstrating compassion, respecting and caring for each other as we interact.
    c. Excellence – doing things right the first time, every time, and being accountable and responsible.
    d. Stewardship – being a community partner responsible for safeguarding care and management of the health system resources while being innovative and providing quality healthcare.
    e. Teamwork – looking out for those we work with, finding ways to support each other in the jobs we do.

D. PHILOSOPHY OF PATIENT CARE SERVICES

1. Tahoe Forest Hospital System is committed to leadership and excellence in integrated healthcare services delivery. Community and patient services at Tahoe Forest Hospital System occur through organized and systematic processes designed to ensure the delivery of safe, effective and timely care and treatment. These structures and functions include:
    a. Mission Statement
        i. The mission statement outlines the hospital values and commitment, which serve as a foundation for planning, implementation and evaluation of goals and objectives.
    b. Planning
        i. Long range planning by the leadership of Tahoe Forest Hospital System in conjunction with the System's Medical Staff and the Board of Directors determines the services offered by the System. The planning process begins with the establishment and communication of the organization's Mission and Philosophy. Guided by these statements, the leaders assess the needs of the community, patients, Medical Staff, hospital staff, and other key stakeholders. Once needs have been determined, leaders develop and implement strategic and operational plans to meet those needs. Goals and objectives are established annually by Tahoe Forest Hospital System leadership.
    c. Prioritization Criteria:
        i. Sustainable business planning requires TFHS prioritize how and where resources will be allocated to meet identified needs. The

following criteria are utilized to assist leaders in prioritization activities:

a. Assure the safety of the physical environment
b. Assure the safety of the providers of care and the recipients of care.
c. Meet legal, regulatory, licensure, and accreditation requirements.
d. Further the Mission and strategic objectives of the organization.
e. Establish desirable outcomes of care for at-risk patient populations
f. Establish the effectiveness, timeliness, and stability of processes that are high-risk, high-volume or problem prone.
g. Determine the effectiveness of the design of new or modified services.

ii. In applying criteria, leadership is sensitive to emerging needs such as those identified through data collection and assessment, changing regulatory requirements, significant patient and staff needs, changes in the physical environment, or changes in the community.

d. Space and Facilities:

i. The planning process also ensures configuration and allocation of all necessary resources, including space, equipment and other facilities to meet specific needs of the patient populations served. The goal of the planning process is to provide effective and efficient patient care by maximizing resource utilization.

e. Type Of Services

i. Patient services are developed which are appropriate to the scope and level required by the patients to be served.

2. Evaluation Of Services

a. Processes exist for ongoing evaluation of patient services including quality improvement activities, patient safety activities, activities of oversight committees, departmental quality control processes, and patient, staff and physician surveys. Results of such activities are reported to the governing body, medical staff and employees.

3. Communication And Committee Structure

a. We encourage information about the healthcare systems performance to flow throughout the organization to accomplish the healthcare systems mission. Communication flows through the organization for healthcare

system employees via the chain of command structure. The medical staff information flows from the service director and department chairman to department meetings and quality review committees. Issues are then referred to the Medical Executive Committee and the Board of Directors.

b. The healthcare system board, leadership, departments, and medical staff all have committees with defined responsibilities. Standing committees and quality improvement program teams serve as the primary vehicles for planning, development, and evaluation. Teams are interdisciplinary. Formal committees are set up, monitored, and evaluated by their oversight function. All quality improvement teams that are interdisciplinary are commissioned and supported by the Hospital Quality Improvement Committee.

E. SCOPE OF SERVICES

1. The District owns and operates two healthcare facilities. Tahoe Forest Hospital, a Critical Access Hospital, is a 25-bed, full-service, not-for-profit healthcare facility serving a wide range of patients. Incline Village Community Hospital, which is based in Incline Village, Nevada and is operated as a four-bed Critical Access Hospital. Both hospitals provide patient care services 24 hours a day, seven days a week, 365 days a year.

a. Tahoe Forest Hospital - Inpatient Services
    i. Surgical Services
    ii. Medical Surgical Unit
    iii. Intensive Care Unit
    iv. Inpatient Oncology
    v. Physical Therapy
    vi. Occupational Therapy
    vii. Speech Therapy
    viii. Medical Nutrition Therapy
    ix. Pharmacy
    x. Radiology
    xi. Computerized Axial Tomography
    xii. Magnetic Resonance Imaging (MRI)
    xiii. Nuclear Medicine
    xiv. Clinical Laboratory
    xv. Women and Family Center
    xvi. Extended Care Center

b. Tahoe Forest Hospital - Outpatient Services
    i. 24-hour Emergency Department;

ii. Ambulatory Surgery;
iii. Cardiac Rehabilitation;
iv. Diagnostic Imaging;
v. PET;
vi. Mammography;
vii. Rehabilitation Therapies;
viii. Clinical Laboratory;
ix. Occupational Health/Workers Comp;
x. Oncology;
xi. Radiation Oncology;
xii. Tahoe Center for Health & Sports Performance;
xiii. Multi-Specialty Clinics;
xiv. Palliative Care;
xv. Mental Health Services;
xvi. Care Coordination;

c. Incline Village Community Hospital - Inpatient Services;
   i. Surgical Services
   ii. Medical Surgical Unit;
   iii. Medical Nutrition Therapy;
   iv. Pharmacy;
   v. Radiology;
   vi. Computerized Axial Tomography
   vii. Clinical Laboratory;
   viii. Physical Therapy/Occupational Therapy

d. Incline Village Community Hospital - Outpatient Services
   i. 24-hour Emergency Department;
   ii. Diagnostic Imaging;
   iii. Mammography
   iv. Ambulatory Surgery;
   v. Clinical Laboratory;
   vi. Multi-Specialty Clinics
   vii. Rehabilitation Therapies

e. Services provided under separate license:
   i. Hospice

ii. Home Health

iii. Retail Pharmacy

iv. On-Site Child Care

F. COORDINATION OF PATIENT SERVICES

1. Patient services at Tahoe Forest Hospital System occur through organized and systematic processes designed to ensure the delivery of safe, effective, and timely care and treatment. Providing patient services and the delivery of patient care require specialized knowledge, judgment, and skill derived from the principles of biological, physical, behavioral, psychological and medical services. As such, patient services will be planned, coordinated, provided, delegated, and supervised by professional health care providers who recognize the unique physical, emotional, and spiritual (body, mind, and spirit) needs of each person. Patient care encompasses the recognition of, disease and health, patient teaching, patient advocacy, and spiritually. Under the auspices of Tahoe Forest Hospital System medical staff, registered nurses and allied health care professionals function collaboratively as part of a multi disciplinary team to achieve positive patient outcomes.
2. In the strictest sense, patient services are limited to those departments that have direct contact with patients. The full scope of patient care is provided by only those professionals who are also charged with the additional functions of patient assessment and planning patient care based on findings from the assessment. Licensed and unlicensed staff provides patient services and patient care. Patient support is provided by a variety of individuals and departments, which may or may not have direct contact with the patients, but who support the care provided by the professional staff providers.

G. COMPETENCY OF THE PATIENT CARE WORKFORCE

1. Clinical leaders and members of the medical and clinical staff assure the provision of quality patient care in all settings, levels, and programs of care through the processes and activities required to develop and maintain a competent workforce. In the planning process, the leaders define staff qualifications and competencies necessary to fulfill Tahoe Forest Hospital System's commitment to patients. Medical, nursing, and allied health professional staff applicants' credentials and qualifications are reviewed prior to affiliation with the institution. During orientation, the education, experience and abilities of new staff members are confirmed. Staff is instructed in Tahoe Forest Hospital System's programs and services; policies, procedures, standards of care, patient care models and protocols; and training and skills testing as appropriate to the staff member's setting and role. Ongoing, periodic competence assessment evaluates staff member's continuing abilities to perform throughout their association with the System.

H. STAFFING

1. The organization recognizes its responsibility to assure sufficient numbers of qualified staff to meet its Mission and scope of services. To accomplish this, each departmental Director is responsible on an ongoing basis to evaluate their staffing

requirements. The Director, when evaluating staffing, will address the following:

a. The number and qualifications of staff necessary for the department to safely perform minimal operations.

b. Identification of the work driver that results in the need to increase the number and/or qualifications of staff to meet the increased work – load of the department.

c. The mechanism by which staffing will be adjusted to meet changes in the work driver.

d. Mechanisms to bring in additional staff if so required.

e. Mechanisms to call off staff if so required.

f. Changes in customer needs and expectations.

2. Staffing levels are monitored on a regular basis to assure an appropriate utilization of resource. Variances to staffing are documented, along with an analysis of why the variance occurred, what actions were taken to address the variance, and the impact on patient care. California Hospitals are mandated to follow nurse patient ratios.

3. The organization is committed to the retention and recruitment of staff. Please refer to TFHD's Human Resources policies and procedures for more detail.

I. ORGANIZATIONAL AND FUNCTIONAL RELATIONSHIPS BETWEEN DEPARTMENTS

1. The interdisciplinary team assesses the patient, identifies patient's needs and develops plans to meet those needs. The Medical Record reflects the interdisciplinary process on the individual patient. Specific collaboration among disciplines is evident in the provision of patient care within a service line. These functional relationships foster communication between and among disciplines with the common goal of caring for a distinct patient population. Service lines are responsible for coordinating the planning of services and evaluation of care.

2. As part of the Quality Improvement Program, each service is responsible to participate in the program. Each department is to continuously improve clinical and operational processes, patient safety, customer satisfaction, and patient outcomes relative to their specific patient populations. Through the Quality Improvement process of plan, do, check, and act, the departments assess and improve key clinical and operational processes and outcomes. Indicators/Measures and/or quality teams are developed, prioritized and reprioritized to identify opportunities to improve care, systems and functions.

J. SCOPE OF CARE AND SERVICES PROVIDED

1. Each department providing patient care is defined by a Scope of Services. The Scope of Services includes:

a. Department Description: department location, hours of service and number of beds;

b. Scope of Services Provided: types and ages of patients served, standards used to guide practice;

c. Organization of the department;

d. Important functions provided by the department; and

e. Staffing plan

K. RESPONSIBILITIES OF LEADERSHIP

1. The Tahoe Forest Hospital District leadership is defined as the Board of Directors, the Chief Executive Officer who oversees the daily functions of the organization; the Chief Operating Officer, Chief Nursing Officer, Chief Financial Officer, Chief Medical Officer, Chief Human Resources Officer, Chief Information and Innovations Officer, and the Vice President of Provider Services; the Medical Executive Committee chaired by the Chief of Staff; The Quality Committee and Operational Directors (see Tahoe Forest Hospital District organizational chart).
2. The Tahoe Forest Hospital District leadership is responsible for planning and evaluating services provided by the organization based on the District's mission and strategic plan. In addition to the collaborative assessment of the Tahoe Forest Hospital District customer and community needs, and the long range strategic plan, the planning process includes development of operational plans, annual operating budgets and monitoring of compliance, annual capital budgets, and ongoing evaluation of the plan's implementation and goal attainments. The planning process minimally addresses both patient care functions and organizational support functions.
3. The Tahoe Forest Hospital District leadership ensures communication of the organization's mission, and strategic plans across the organization through education and training, staff meetings and interdisciplinary strategic planning.
4. The Tahoe Forest Hospital District leadership establishes standards of care that all patients can expect and which can be monitored through the Hospital Quality Assessment Committee. These standards are expressed in patient rights and education materials provided to the patient.
5. The Tahoe Forest Hospital District leadership ensures the facility complies with all applicable Federal, State and local laws relating to the health and safety of patients.
6. The Tahoe Forest Hospital District leadership provides appropriate job enrichment, employee development and continuing education opportunities which serve to promote retention of staff and to foster excellence in care delivery and support services through the assessment of staff needs and the implementation of educational development programs.
7. The Tahoe Forest Hospital District leadership ensures appropriate direction, management and leadership of all services and departments through the screening, hiring, and deployment of service line directors according to established criteria.
8. The Tahoe Forest Hospital District leadership ensures staffing resources are available to appropriately meet the needs of the patients served through the development and implementation of annual operating budgets, monitoring of patient care requirements and quality care indicators.
9. The Tahoe Forest Hospital District leadership strives to ensure that systems are in place, which promotes the integration of services supporting the patient's continuum of care needs in ways appropriate and useful to the customer. This includes the

utilization of admission, transfer and discharge criteria, and referral to appropriate community resources.

10. The Tahoe Forest Hospital District leadership involves medical staff and directors in evaluating, planning and recommending annual expense and capital objectives and expense budgets based on the expected resource needs of their service lines. Directors are accountable for managing and justifying their budgets and resource utilization, including new technologies, which can be expected to improve the delivery of patient care and services.

L. SUPPORT SERVICES

1. Other healthcare system services are available and provided to ensure that direct patient care and services are maintained in an uninterrupted and continuous manner, by coordinating identified organization functions such as leadership/management, information systems, human resources, environment, infection controls, and organizational performance improvement. These services support the comfort and safety of the patient and efficiency of services available. These services will be fully integrated with the patient services departments of the healthcare system.

References:

CoP 485.635(a)(3)(i); HFAP 01.00.01

Approval Signatures

Step Description	Approver	Date

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Origination Date	N/A	Department	Governance - AGOV
Last Approved	N/A	Applicabilities	Incline Village Community Hospital, Tahoe Forest Hospital
Last Revised	N/A		
Next Review	N/A		

Hand-Off Communications, SBAR and C-U-S Reports, AGOV-1504

RISK:

~~Transitions of patient care between providers occur frequently and require providers to transmit critical clinical information. If information is omitted or misunderstood, there may be serious clinical consequences. This policy is in place to reduce risk of patient harm by delineating a consistent process to ensure that comprehensive, accurate, and current information is communicated regarding the patient's care and identify a process to escalate communication of patient safety concerns.~~

If standardized SBAR, Hand-Off, and C-U-S communication processes are not consistently followed, critical patient information may be omitted, misunderstood, or not escalated in a timely manner, which could result in delays in clinical response, inappropriate care decisions, adverse events, and preventable patient harm.

POLICY:

A. The language used is clear and objective. Terms or abbreviations that could be misinterpreted are avoided.

B. Sufficient time is allocated for the communication of patient information. Interruptions are minimized. The receiver of the patient information will have the opportunity to review relevant historical data and treatment plans as needed and appropriate.

C. Hand-off communications and Situation-Background-Assessment-Recommendation (SBAR) reports are interactive, allowing the opportunity for questioning between the giver and receiver of information.

D. To assure accuracy and understanding, the receiver of information will read back certain information, such as critical test results and orders for any changes in patient treatment/ medication. The communicator will request the ordering clinician to confirm that the read-back

was correct.

E. Clinicians who report clinical information during transitions of care are responsible for hand-off communication. (The process does not extend to non-clinical patient transporters such as hospital volunteers). Clinicians who report acute changes in patient's condition requiring a clinical response are responsible for using the SBAR format.

F. When there has been an acute change in the patient's condition that requires a clinical response, SBAR report is used.

G. When there has been a transition in the provider, location or setting for patient care, Hand-Off communication is used.

H. When staff need to escalate communication of patient safety concerns to the healthcare team, C-U-S Protocol is used.

PROCEDURE:

A. SBAR Report to communicate an acute change in the patient's condition that requires a clinical response:

1. **(S) SITUATION** : What is the situation (acute change in patient condition) being reported?
    a. Identify self, patient and location.
    b. Briefly state the change in condition being reported (what you are concerned about).
2. **(B) BACKGROUND:** Pertinent background on the acute change in condition could include:
    a. The chronology of the change (possibly admission date and diagnosis).
    b. Current medications.
    c. Most recent clinical/physical assessment and vital signs.
    d. Date/time of past, current lab/imaging results; pending results not yet known.
    e. Code status and/or other relevant clinical information.
3. **(A) ASSESSMENT:** What is the clinical assessment of the situation?
    a. Condition that has changed and now requires a clinical response.
4. **(R) RECOMMENDATION:** What clinical response does the reporter want to address the acute change in the patient's condition? The recommendations could include:
    a. The patient needs to be seen now.
    b. The patient needs revised or new orders for treatment of the change in condition.
    c. The patient needs a change in the level of care.

B. Hand-Off communication for a transition in the provider, location or setting for patient care:

1. Hand-off communication occurs when patients transition to different care settings,

location or care providers. Examples of hand-off communications include, but are not limited to:

a. Nursing shift changes
b. Temporary change of provider, i.e., staff leaving the unit for a short time period
c. Physician transferring responsibility for a patient to another physician, either temporarily or permanently
d. Anesthesiologist hand-off of patient to the PACU nurse
e. Perioperative nurses hand-off of patient within the department (pre-procedure, operative and post anesthesia recovery areas)
f. Transfer from the Emergency Department to an inpatient care setting
g. Transfer to a different patient care area
h. Transfer to a different hospital, nursing home, home health, or other entity assuming care of the patient
i. Critical lab and radiology test results communicated to physician offices as part of a status report

2. Specific to nurse hand-off at shift change and/or the transition between care settings:
    a. Nurses will, at minimum, complete an RN to RN report of the following:
        i. Diagnosis
        ii. Patient Condition
        iii. Care
        iv. Treatment and medications
        v. Pending test or procedure results
        vi. Discharge plans
        vii. Changes in plan of care
    b. Standardized communication tools are available via the EMR to provide efficient access to the above require communication elements.

C. C-U-S Protocol to escalate communication of patient safety concerns to the healthcare team.
    1. When a caregiver perceives that the clinical process has departed significantly from the intended plan, the following process will be used to communicate a concern about patient safety. This process uses the continuous assertion model described below until the safety issue is resolved.
    2. Procedure for using the C-U-S Protocol
        a. Get the person's or team's attention.
        b. Express the specific concern.
        c. State the problem needing resolution.

d. Propose action(s) to resolve the problem.

e. Reach a decision on resolution through team consensus.

f. When the patient safety issue continues to be unresolved, the caregiver will escalate the team's attention by stating:

g. "I am **C-ONCERNED!"** (followed by using the assertion model above)

h. "I am **U-NCOMFORTABLE** !" (followed by using the assertion model above)

i. "This is a patient **S-AFETY** issue!" (followed by using the assertion model above)

3. For any situation where the C-U-S Protocol fails to resolve a hazard to patient safety, or if the hazard is worsening, the nursing or medical staff chain of command will be initiated.

D. GENERAL INSTRUCTIONS:

1. Speak up whenever there is a concern about patient safety.

   a. At any point, any team member can stop the line and request a time out or team huddle to discuss the plan of care.

2. The receiver of the patient information will have the opportunity to review relevant historical data, records and treatment plans as needed and appropriate. An opportunity for the receiver to ask questions of the reporter will be provided each time a SBAR, Hand-Off communication or transfer of care occurs.

3. A **Transfer and Referral Record** and **Transfer Physician Certification** form will be used to communicate information for patients being transferred to another facility and to home care agencies.

REFERENCES:

National Quality Forum: "Safe Practices for Better Healthcare-2/2013 Update."

Attachments

1: Hand-Off Communication Tool

2: SBAR Communication Tool to Physicians or L.I.P.

Approval Signatures

Step Description	Approver	Date

Status **Draft** PolicyStat ID **20062533**

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

Medical Device Tracking, AGOV-1605

RISK:

Medical device tracking information, and reporting, is imperative to facilitate notifications, and recalls ordered by the FDA, if serious risks to health are identified with the devices.

PURPOSE:

A. To comply with Code of Federal Regulations 821 Medical Device Tracking Requirements.

B. Manufacturers are required to track certain devices from their manufacture through the distribution chain when they receive an order from the Food and Drug Administration (FDA) to implement a tracking system for a certain type of device. The purpose of device tracking is to ensure that manufacturers of certain devices establish tracking systems that will enable them to promptly locate devices in commercial distribution. Tracking information may be used to facilitate notifications and recalls ordered by FDA in the case of serious risks to health presented by the devices. Final distributors of these devices will be required to provide manufacturers with patient information.

C. The types of devices subject to a tracking order may include any Class II or Class III device:

1. the failure of which would be reasonably likely to have serious adverse health consequences;
2. which is intended to be implanted in the human body for more than one year; or
3. which is intended to be a life sustaining or life supporting device used outside a device- user facility.

POLICY:

A. Devices Subject to Tracking

1. The FDA has issued orders to manufacturers who are required to track the following implantable devices:

a. Glenoid Fossa prosthesis
b. Mandibular condyle prosthesis
c. Temporomandibular Joint (TMJ) prosthesis
d. Abdominal Aortic Aneurysm Stent Grafts
e. Automatic implantable cardioverter/defibrillator
f. Cardiovascular permanent implantable pacemaker electrode
g. Implantable pacemaker pulse generator
h. Replacement heart valve (mechanical only)
i. Implanted cerebellar stimulator
j. Implanted diaphragmatic/phrenic nerve stimulator
k. Implantable infusion pumps
l. Silicone Gel-Filled Breast Implants
m. Cultured Epidermal Autografts

2. The FDA has issued orders to manufacturers who are required to track the following devices that are used outside a device-user facility:
    a. Breathing frequency monitors
    b. Continuous Ventilators
    c. DC-defibrillators and paddles
    d. Ventricular Bypass (assist) Device; abdominal left ventricular assist device (ALVAD)

B. Tracking Responsibility
    1. Manufacturers
        a. For the above items, manufacturers have the responsibility to identify devices that meet the criteria for tracking and to initiate tracking. The hospital has the responsibility upon purchasing, or otherwise acquiring any interest in such a device, to promptly provide the manufacturer tracking the device with the following information:
            i. The name and address of the distributor, final distributor or multiple distributor;
            ii. The lot number, batch number, model number, or serial number of the device, or other identifier used by the manufacturer to track the device;
            iii. The date the device was received;
            iv. The person from whom the device was received;
            v. If and when applicable, the date the device was explanted, the date of the patient's death, or the date the device was returned to the distributor, permanently retired from use, or otherwise

permanently disposed of.

b. Upon delivery to the patient of a single use device or Implantable device, the hospital, as final distributor, shall promptly provide the manufacturer tracking the device with the following information:
    i. The name and address of the (final distributor), hospital.
    ii. The lot number, batch number, model number, or serial number of the device, or other identifier used by the manufacturer to track the device;
    iii. The name, address, telephone number, and social security number (if available) of the patient receiving the device;
    iv. The date of the device was provided to the patient for use in the patient;
    v. The name, mailing address, and telephone number of the prescribing physician;
    vi. The name, mailing address, and telephone number of the physician regularly following the patient if different than the prescribing physician; and
    vii. When applicable, the date the device was explanted and the name, mailing address, and telephone number of the explanting physician, the date of the patient's death, or the date the device was returned to the manufacturer, permanently retired from use, or otherwise permanently disposed of.

c. This information shall be provided to the manufacturer on their forms.

2. Outside Device-User Facility

Life-supporting or life sustaining device used outside a device-user facility means a device which is essential, or yields information that is essential, to the restoration or continuation of a bodily function important to the continuation of a human life that is intended for use outside a hospital, nursing home, ambulatory surgical facility, or diagnostic or outpatient treatment facility.

a. When a life sustaining or life supporting device will be used by more than one patient (such as a mechanical ventilator, IV pump, apnea monitor, etc.) and the device is used outside the hospital, the hospital will keep written records each time the device is distributed for use by a patient that will include the following:
    i. The lot number, batch number, or model number, or serial number of the device, or other identifier used by the manufacturer to track the device;
    ii. The name, address, telephone number, and social security number (if available) of the patient using the device;
    iii. The location of the device;

iv. The date the device was provided for use by the patient;

v. The name, address, and telephone number of the prescribing physician;

vi. The name, address, and telephone number of the physician regularly following the patient if different than the prescribing physician; and

vii. When applicable, the date the device was permanently retired from use or otherwise permanently disposed of.

viii. These records will be available upon request to the manufacturer within 5 working days, and to the FDA, upon request, within 10 working days.

3. Other involved departments:
    a. Home Health
    b. Nursing
    c. Pharmacy
    d. Practice Management
    e. Purchasing
    f. Respiratory Therapy
    g. Retail Pharmacy
    h. Surgery
    i. Cancer Center

References:

~~21 CFR 821 Medical Device Tracking Requirements~~21 CFR 821 Medical Device Tracking Requirements; ~~Medical Device Tracking~~Medical Device Tracking; ~~Medical Device Tracking Guidance~~Medical Device Tracking Guidance; ~~21 CFR 860 Medical Device Classification Procedures~~21 CFR 860 Medical Device Classification Procedures

Attachments

Medical-Device-Tracking---Guidance-for-Industry-and-FDA-Staff.pdf

Approval Signatures

Step Description	Approver	Date

Status **Pending** PolicyStat ID **20106408**

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Department	Board - ABD
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Physician and Professional Service Agreements, ABD-21

RISK:

In the absence of clear guidelines for entering into Professional Service Agreements with physicians and other health professionals, Tahoe Forest Hospital District ("TFHD" or "District") could be exposed to significant legal and/or financial liability.

SCOPE:

This policy provides Tahoe Forest Hospital District's Chief Executive Officer ("CEO") a framework for professional services contracting. to ensure the professional service provider meets the needs of Tahoe Forest Hospital District ("TFHD" or "District") and the communities that it serves.

This policy provides no guidance or authority for employed physicians or other providers.

POLICY:

A. Written professional service agreements (which do not include employment offers) will be prepared for all health professionals who qualify as independent contractors under IRS guidelines and provide diagnostic or therapeutic services to TFHD's patients or provide certain medico-administrative duties within a hospital department or service.

B. The following health professionals may be covered by this policy:

    1. Anesthesiologists
    2. Medical Directors
    3. Medical Staff officers
    4. Physicians providing services in the District's Multi-Specialty Clinics, Cancer Center or other professional practice settings operated by TFHD (collectively, "TFHD

Practice Settings").

5. Physicians serving in medical-administrative roles or on District committees
6. Nuclear Medicine specialists
7. Emergency Services physicians
8. Occupational therapists
9. Pathologists
10. Physical therapists
11. Radiologists
12. Speech pathologists
13. Emergency and urgent care providers
14. Hospitalists
15. Other contracted health or medical service providers

C. Any physician who is employed by the District may not simultaneously work under a professional services agreement.

PROCEDURES:

A. All professional service agreements will be developed between the CEO, or the CEO's designee, and the health professional.

1. Health professionals are not permitted to provide professional services until an agreement has been approved by the District prior to the agreement effective date. All PSAs and offers of employment will be reviewed by in-house legal counsel and compliance prior to offering to a physician. Signatures will be obtained prior to the agreement effective date or in accordance with current Stark Law. Agreements containing amendments to the terms and conditions of the agreement must also be executed prior to the effective date and prior to the provision of professional services under the amended agreement.
2. New and renewal agreements shall utilize the template agreement for the type of service required from the contracting professional. (See Exhibit A, attached, for a list of available model agreements.)
3. All agreements shall be reviewed by the Compliance Department. Agreements not utilizing the template agreement shall also be reviewed by legal counsel.
    a. Agreements committing $400,000.00 or more in any twelve-month period:
        i. Once agreement is reached between the CEO and health professional, CEO will present the provider-signed professional services agreement to the Board of Directors with the Contract Routing Form (or equivalent data summary report) with principal terms and conditions for their consideration. Principal terms and conditions include, but are not limited to, justification, term, compensation, scope of duties, total cost of contract, and other pertinent information, as applicable.

ii. Upon review and consideration, the Board of Directors may request specific changes be made to the proposed terms and conditions or direct a designated Board committee to review and make a recommendation to the Board of Directors.

iii. Board approval of a professional services agreement constitutes direction to CEO to execute the professional service agreement.

b. Agreements committing less than $400,000 in any twelve-month period may be authorized by the CEO without Board approval.

4. Professional service agreements due for renewal may be held over for up to twelve months with no change in terms at the discretion of the CEO and in accordance with the Stark Law and applicable regulations. Note: Stark Law regulations currently permit unlimited holdover of physician professional service agreements when the contract stays within the fair market value.

5. Urgent Services: At the discretion of the CEO, a professional service agreement required for urgent services may be executed if a quorum for a Special Meeting of the Board of Directors cannot be assembled.

B. Compensation under Professional Service Agreements (PSA) With Physicians Only

1. New and renewal agreement will specify the financial arrangements related to the provision of physician professional services.

a. In no case shall compensation to physicians take into account the volume or value of anticipated or actual referrals physicians make to TFHD.

b. Management shall strive to create financial terms that are aligned with the following organizational goals, recognizing that simultaneous achievement of all goals may not be possible in all cases; however the first of these goals (paying within fair market value) cannot be compromised in any circumstance.

i. Pay within constraints of fair market value

ii. Maintain internal equity within and between specialties

iii. Provide sufficient compensation to recruit and retain physicians

iv. Encourage quality and productivity

v. Be clear and understandable to all parties

2. The methodologies in the following section may be utilized to determine compensation with physicians.

a. Hourly rates or "per shift" rates with hours of coverage and response time specified.

i. Physicians shall be required to document and attest to the date, hours worked or shifts covered.

ii. In addition, a description of work completed or meetings attended will be provided for all administrative duties.

b. Rate per unit of production.
    i. The Work Relative Value Unit (WRVU) is the preferred measure of physician productivity and should be used as the unit of production whenever feasible.
    ii. An alternate measure of productivity such as visits may be used as deemed necessary by management.

c. Fixed Stipend.
    i. The scope of work performed in exchange for the fixed stipend shall be clearly defined. The definition may include an agreed number of days of work and/or hours of clinical availability per period of time
    ii. A production-based bonus and/or value-based incentive may be offered in addition to the fixed stipend, to align with organizational objectives.

d. Payment per service. Payment at a specified rate per service is a permitted method for limited scope agreements in which the physician is providing clearly delineated clinical services. Examples include EKG interpretations, audiology reviews, and other services that are billed on a global basis by the hospital.

e. Specialty call activation fee. In specialties where a regular on-call panel is either infeasible due to the number of physicians on the medical staff within that specialty or the low incidence of emergency need for that specialty, a specialty activation fee may be offered in the event that physician is called in to respond to an emergency.

f. Reimbursed expenses
    i. A contracted physician's direct expenses associated with the performance of duties under the professional services agreement may be reimbursed. These may include, but are not limited to:, malpractice insurance expense, IRS-allowable travel expenses, temporary lodging, medical staff application fees / annual dues, medical licenses, and continuing medical education.

g. Fair Market Value. In all cases, physician's total compensation must be within fair market value and must be determined to be commercially reasonable.

C. Multiple Agreements

1. Nothing in this policy shall prohibit TFHD from entering into multiple agreements with health professionals, provided the designated hours and types of service are clearly segregated.
    a. Physicians whose professional duties under a PSA are during regular Monday through Friday daytime hours may have a separate agreement for

on-call coverage during evenings, weekends, and scheduled days off and/or for administrative duties performed during lunch or after regular clinic hours.

b. Physicians working in a TFHD Practice Setting who provide hospitalist, on-call, or administrative services during normal scheduled clinic time shall receive WRVU credit in lieu of cash payment.

c. A physician may perform administrative duties while on call, as long as clinical duties are not needed. If a physician is needed for clinical duties, they may not bill administrative time when performing clinical duties.

d. Fair market valuations shall take into account the existence of multiple agreements with one contracting physician.

D. Physician Qualifications

1. Professional service agreements with physicians shall require:

a. A valid and unrestricted license to practice medicine in the state issued by the applicable state Medical Board.

b. Physician must achieve Board certification when eligible and/or maintain Board certification.

c. The physician is not suspended or excluded from participating in any federal health program.

d. All appropriate certifications, registrations and approvals from the Federal Drug Enforcement Administration and any other applicable federal or state agency necessary to prescribe and dispense drugs under applicable federal and state laws and regulations, in each case without restriction.

e. Prompt disclosure of the commencement, resolution or pendency of any action, proceeding, investigation or disciplinary proceeding against or involving physician, including, without limitation, any medical staff investigation or disciplinary action.

f. Prompt written notice of any threat, claim, or legal proceeding against TFHD that physician becomes aware of, and cooperation with TFHD in the defense of any such threat, claim, or proceeding and in enforcing the rights (including rights of contribution or indemnity) that TFHD may have against other parties or through its insurance policies.

g. No discrimination against a patient based on race, color, creed, religion, national origin, gender, sexual orientation, disability (including, without limitation, the condition(s) for which the patient seeks professional services from physician), marital status, age, ability to pay or payment source, or any other unlawful basis.

2. Physician Qualifications In Coordination With Medical Staff Bylaws:

a. Professional service agreements with physicians shall require their membership on the respective hospital's Medical Staff with appropriate privileges pertinent to the duties and responsibilities described by the professional service agreement.

b. Termination of the agreement will cause the physician to lose the contractual "right" to provide the services which are described in the agreement. However, this would not mean that the physician would lose Medical Staff membership and privileges; he/she would simply lose the right to gain access to the service or department which is the subject of the exclusive agreement.

3. Contract Termination Clause
    a. In all cases, professional service agreements shall provide for a termination clause which allows for termination by either party without cause upon prior written notice.
    b. The following language will be utilized:
        i. "For cause" termination of a physician contract at any time during the term;
        ii. "No cause" termination during the initial or subsequent term. In the event a "no cause" termination occurs during the first year of the agreement, the parties may not enter into a new agreement for substantially the same services until after the expiration of the initial one-year term of the agreement.
        iii. The time-frame for prior written notice may range from 60–180 days. Further, termination of the agreement does not afford the physician the right to request a medical staff hearing or any other review under the Medical Staff By-Laws or rules and regulations, based on termination of the agreement.

E. Provisions For Non-Physician Health Professional Service Agreements
1. In all cases, the contract will specify the financial arrangements related to the provision of professional services. It is desirable that remuneration be based upon a set professional fee schedule rather than a percentage of gross or net patient charges. However, it is recognized that a wide variety of other mechanisms may be utilized and such other mechanisms are left to the discretion of the CEO and Board of Directors.
2. Compensation for health professional service agreements shall not exceed fair market value of the services.
3. Professional Fee Schedule
    a. When reimbursement is based upon professional fee schedules, the fee schedule will be made a part of the agreement with the health professional. When provided for by agreement, professional fee schedule revisions will be considered once annually in a time-frame that coincides with the District's operating budget.
    b. Requests for revisions should be submitted to the CEO by April of each year for implementation by July. The request should provide sufficient detail to fully describe the professional services, relevant code numbers and professional fees requested. The CEO determines whether the

proposed changes are acceptable.

4. Health Professional Qualifications in Coordination with Medical Staff By-Laws:
    a. Professional service agreements may require certain health professionals to be members of the District's allied health professional staff with appropriate privileges pertinent to the duties and responsibilities described by the professional service agreement.
    b. Should a health services agreement be cancelled involving an allied health professional, termination of the agreement will cause the health professional to lose the contractual "right" to provide the services which are described in the agreement. However, this would not mean that the health professional would lose allied health professional appointment or related privileges.
5. Contract Termination Clause
    a. In all cases, professional service agreements shall provide for a termination clause which allows for termination by either party without cause upon written notice.
    b. The time frame for prior written notice may range from 60–180 days. When the health professional is required to be an allied health professional, termination of the agreement will not afford the allied health professional the right to request a due process hearing under any Medical Staff bylaw, rule, or regulation for allied health professionals, based on termination of the agreement.
    c. In all cases, professional service agreements will provide for termination "for cause" at any time during the contract term.

F. Physician and Health Professional Service Agreement Contract and Service Review
    1. At a minimum of every five years, the CEO or CEO's designee will conduct a service review of the contract service provided by the physician, physician group and/or other professional service.

G. General Contract Inclusion Terms: Physician and Health Professional Service Agreements
    1. Professional Service Duties and Responsibilities: Each agreement will include a detailed and specific delineation of the duties and responsibilities to be performed by the health professional as well as the District. For example, extensive detail will be provided regarding:
        a. Diagnostic and therapeutic services to be provided
        b. Medico-administrative services to be provided
        c. Coverage obligations to be assumed
        d. The rights and obligations of the District and the health professional with regard to providing space, equipment, supplies, personnel and technicians.
    2. Standards of Practice: Each agreement shall specify that the health professional will provide the service in accordance with the Hospital Bylaws; Medical Staff Bylaws,

Rules and Regulations, and if applicable, standards established by the Executive Committee of the Medical Staff;

3. Medicare and Medicaid Enrollment: Each agreement shall specify that the health professional is duly enrolled in the federal Medicare program and the applicable State Medicaid program (unless excepted by the District) and eligible to seek reimbursement under such programs for covered services rendered by the provider to beneficiaries of such programs. Every agreement must contain a provision in which the health professional agrees to notify TFHD in the event participation terminates.
4. Quality Assessment: Professional service agreements shall require the health professional to participate in the Health System Quality Improvement Program to ensure that the quality, safety and appropriateness of healthcare services are monitored and evaluated and that appropriate actions based on findings are taken to promote quality patient care. Furthermore, each agreement shall specify a process designed to assure that all individuals who provide patient care services under service agreements, but who are not subject to the Medical Staff privilege delineation process, are competent to provide such services. Whenever possible, information from customer satisfaction surveys shall be incorporated into the Quality Improvement Program for the service. Agreements which provide for Directorship responsibilities over a department or service shall require the health professional "Director" to be responsible for implementing a monitoring and evaluation process designed to improve patient care outcomes and which is integrated with the Health System Quality Improvement Program.
5. Assignability: It is desirable that all professional service agreements be non-assignable unless important to the successful negotiation of a contract where higher priority objectives may be achieved. Where assignability becomes necessary, assignability shall be allowed only with the condition that prior written consent of the District be obtained.
6. Contract Term: Professional service agreements shall specify an effective date that is later than all requirements, including credentialing, being met. In considering the term of the agreement, the termination date of related agreements should be considered by the CEO so as to minimize the likelihood of multiple agreements coming due on the same date or year. The length of the term shall be negotiable. Professional service contracts will typically range from one to four years in duration.
7. Professional Liability: In all cases, the health professional will be responsible for providing adequate professional liability insurance coverage at the health professional's expense. Limits of coverage for physicians will be a minimum of $l,000,000 per occurrence, $3,000,000 aggregate. For non-physicians, the minimum limits of coverage may vary depending on the standard established for that health profession in consultation with the District's risk manager. The agreement shall also specify that the contracting health professional will, in turn, either require or arrange for professional liability insurance coverage for all sub-contracting health professionals. Furthermore, the professional liability insurance policy must be obtained from a professional liability insurer which is authorized to transact the business of insurance in the State of California (or Nevada in the case of

professional services provided at the District's Nevada-based facilities). Also, the professional services agreement must require that the selected insurer will be responsible for notifying the District of any cancellation or reduction in coverage within thirty days of such action.

8. Regulatory Compliance: The agreement should include provisions in which both the District and the health professional commit to full compliance with all federal, state, and local laws. The contracting party should agree to keep confidential any financial, operating, proprietary, or business information relating to the District and to keep confidential, and to take the usual precautions to prevent the unauthorized use and disclosure of any and all Protected Health Information. The agreement should include provisions for amendment to the agreement in furtherance of maintaining compliance in the event of the adoption of subsequent legislation and/or regulations.
9. Recitals: Exclusive professional service agreements should include a carefully developed description of the rationales for exclusivity in a particular clinical service or department. Furthermore, if the agreement does assign exclusive responsibility for a particular service, it should state so expressly not leaving this to inference or interpretation.
10. Professional Relationships: The agreement should specify that the health professional is an independent contractor and is not an employee of the District.
11. Government Audit: The agreement should include the standard provision recognizing that the agreement and certain other materials will be subject to audit and inspection by certain federal authorities with regard to payments made for Medicare services.
12. Standard Contractual Language: The agreement should include certain standard provisions to the effect that the provisions of the contract are severable and, therefore, the ruling that any one of them is void does not invalidate the entire agreement, and that the waiver of breach of one provision does not constitute a continuing waiver, and that the written agreement constitutes the entire contract between the parties.
13. Managed Care: The physician or health professional agrees to participate as a preferred provider with all of the managed healthcare plans (PPOs and HMOs) that the District has agreements with including agreements with insurance companies, health maintenance organizations and direct contracting with self-funded employers. Any deviation of this policy must be approved by the CEO and the Board of Directors.

All Revision Dates

03/2026, 12/2022, 12/2019, 07/2017, 09/2016, 07/2015, 02/2014, 01/2014, 01/2012, 01/2010, 05/2000

Approval Signatures

Step Description	Approver	Date
	Anna Roth: President & CEO	Pending
	Sarah Jackson: Executive Assistant, Clerk of the Board	03/2026

Status **Draft** PolicyStat ID **19407774**

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

Available CAH Services, TFH & IVCH, AGOV-06

RISK:

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

POLICY:

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

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

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

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

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

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

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

TAHOE FOREST HOSPITAL DISTRICT

A. The following services are available directly at Tahoe Forest Hospital:

1. Emergency Services
2. Inpatient Medical Surgical Care
    a. Medical Surgical Pediatric care
3. Intensive Care and Step Down
    a. Step Down Pediatric care (age 7-17)
4. Swing Program
5. Obstetrical Services
6. Inpatient and Outpatient Surgery
7. Outpatient Observation Care
8. Inpatient and Outpatient Pharmacy Service
9. Medical Nutritional / Dietary Service
10. Respiratory Therapy Services
11. Rehabilitation Services that includes Physical, Occupational,~~and~~ Speech Therapy, and Wound Care
12. Inpatient and Outpatient Laboratory Services, including blood transfusion
13. Diagnostic Imaging Services that includes: PET CT, Radiation, CT Scan, MRI, Mammography, Ultrasound, Fluoroscopy, Bone Density Scan (DEXA), and Nuclear Medicine
14. Cancer Center, including Outpatient and Inpatient infusion therapy, and Radiation Oncology Center
15. Home Health
16. Hospice
17. Palliative Care
18. Skilled Nursing Care
19. Outpatient Services that includes Wellness ~~program~~Programs, Cardiac & Pulmonary Rehabilitation, Occupational Health Services, Multispecialty Clinics, Rural Health ~~Clinic~~Clinics including Behavioral Health and Addiction Medicine Clinics, and Audiology

20. ~~Medical and Radiation Oncology Services~~Urgent Care Services

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

C. Telemedicine Agreements at Tahoe Forest Hospital:
    1. Psychiatric Telemedicine Services (CEP-America Psychiatry PC d/b/a Vituity)
    2. Tele-Stroke and Emergent Tele-Neurology Services (Telespecialists, LLC)

3. Oncology Telemedicine Services (UC Davis)
4. Neonatal & Pediatric ICU Telemedicine Services (UC Davis)
5. Anthem Blue Cross of California
6. Alina Telehealth
7. Plumas District Hospital
8. Barton Memorial Hospital

D. The following services are provided to patients by Agreement or Arrangement at Tahoe Forest Hospital:
    1. Emergency Professional Services
    2. On Call Physician Program
    3. Hospitalist Services
    4. Pathology and Laboratory Professional Services
    5. Blood and Blood Products Provider: United Blood Services Reno, NV
    6. Diagnostic Imaging Professional Services
    7. Anesthesia Services
    8. Pharmacy Services
    9. Telehealth Services
    10. Tissue Donor Services
    11. Biomedical Services
    12. Interpreter Services
    13. Audiology Services
    14. Dosimetry and Physics Services

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

and Speech Therapy

F. Transfer Agreements at Incline Village Community Hospital provide other needed services as outlined in the Transfer Agreements:
    1. Renown Regional Medical Center (Reno, NV)
    2. Saint Mary's Regional Medical Center (Reno, NV)
    3. Carson Tahoe Hospital (Carson City, NV)
    4. Carson Valley Medical Center (Gardnerville, NV)
    5. Tahoe Forest Hospital (Truckee, CA)
    6. Barton Healthcare System (South Lake Tahoe, CA)
    7. Northern Nevada Medical Center (Sparks, NV)
    8. Northern Nevada Sierra Medical Center (Reno, NV)
    9. Hearthstone of Northern Nevada (Sparks, NV)
    10. Banner Health
    11. Emergency Transportation Agreement with:
        a. North Lake Tahoe Fire Protection (Incline Village, NV)
        b. Careflight

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

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

12. Dosimetry and Physics Services

References:

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

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

Approval Signatures

Step Description	Approver	Date

AGENDA ITEM COVER SHEET

MEETING DATE: March 26, 2026	**ITEM:** 14.5. **Quality Assessment/Performance Improvement (QA/PA) Plan, AQPI-05 Policy**
DEPARTMENT: Quality & Regulations	**TYPE OF AGENDA ITEM:** ☐ Action ☒ Consent ☐ Discussion
RESPONSIBLE PARTY: Johanna Koch, MD, Chief of Staff	**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:
Respective Departments have reviewed Department Policies and Privileges, recommended approval to MEC. During the March 19, 2026 Medical Executive Committee meeting, the MEC reviewed and recommended approval to the Board of Directors for the March 26, 2026 Regular Meeting of the Board of Directors. This policy and AGOV-06 were the last remaining parts of the Annual Quality Assurance / Performance Improvement Plan that was approved by the Board in February 2026.

SUMMARY/OBJECTIVES:

SUGGESTED DISCUSSION POINTS:
Medical Executive Committee has reviewed the Department recommendations on privileges and policies. 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 policy consent agenda as presented.

Alternative: If a specific Policy, Procedure or Form is pulled from the consent agenda, provide discussion under Item 17 on the Board Agenda. After discussion, request a motion to approve the pulled item as presented.

LIST OF ATTACHMENTS:

Quality Assessment/Performance Improvement (QA/PA) Plan, AQPI-05 Policy(redline)

Status **Draft** PolicyStat ID **19296284**

Origination Date	N/A
Last Approved	N/A
Last Revised	N/A
Next Review	N/A

Department	Quality Assurance / Performance Improvement - AQPI
Applicabilities	System, Truckee Surgery Center

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

RISK:

~~Organizations who respond reactively, instead of pro-actively, to unanticipated adverse events, and/or outcomes, lack the ability to mitigate organizational risks by reducing or eliminating contributing factors. This is a risk for poor quality care and patient outcomes.~~

Risks to patient safety, clinical outcomes, operational efficiency, and regulatory compliance may arise from variations in care delivery, human factors, system failures, environmental conditions, or breakdowns in communication. These risks have the potential to result in patient harm, decreased quality of care, workflow inefficiencies, financial loss, or reputational damage if not proactively identified and managed.

POLICY:

The Quality Assessment/Performance Improvement (QA/PI) plan provides a framework for promoting and sustaining performance improvement at Tahoe Forest Health System, in order to improve the quality of care and enhance organizational performance. An effective plan will pro-actively mitigate organizational risks by eliminating, or reducing factors that contribute to unanticipated adverse events and/or outcomes, in order to provide the highest quality care and service experience for our patients and customers.This will be accomplished through the support and involvement of the Board of Directors, Administration, Medical Staff, Management, and employees, in an environment that fosters collaboration and mutual respect. This collaborative approach supports innovation, data management, performance improvement, proactive risk assessment, commitment to customer satisfaction, and High Reliability principles to promote and improve awareness of patient safety. Tahoe Forest Health System has an

established mission, vision, values statement, and utilizes a ~~foundation of excellence~~winning aspirations model, which are utilized to guide all improvement activities.

MISSION STATEMENT

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

VISION STATEMENT

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

VALUES STATEMENT

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

A. Quality – holding ourselves to the highest standards, committing to continuous improvement, and having personal integrity in all we do
B. Understanding – being aware of the concerns of others, demonstrating compassion, respecting and caring for each other as we interact
C. Excellence – doing things right the first time, every time, and being accountable and responsible
D. Stewardship – being a community partner responsible for safeguarding care and management of health system resources while being innovative and providing quality healthcare
E. Teamwork – looking out for those we work with, findings ways to support each other in the jobs we do

WINNING ASPIRATIONS

A. Our winning aspirations includes:
    1. Community – aspire to be an integrated partner in an exceptionally healthy and thriving community
    2. Service – aspire to deliver a timely, outstanding patient and family experience
    3. Quality – aspire to deliver the best possible outcomes for our patients
    4. People – aspire for a highly engaged culture that inspires teamwork and joy
    5. Finance – aspire for long-term financial strength

PERFORMANCE IMPROVEMENT INITIATIVES

A. The ~~2025~~2026 performance improvement priorities are based on the principles of STEEEP™, (Safe, Timely, Effective, Efficient, Equitable, Patient Centered Care) and the ~~Quadruple~~Quintuple Aim (IHI, 2022):

1. Improving the patient experience of care (including quality and satisfaction);
2. Improving ~~the~~population health ~~of populations~~;
3. Reducing the per capita cost of health care;
4. ~~Staff engagement and joy in work.~~
5. Improving workforce well-being;
6. Advancing health equity.

B. Priorities identified include:

1. Exceed national ~~benchmark with~~benchmarks for quality of care and patient satisfaction ~~metric results with a focus~~by focusing on process improvement and performance excellence .
    a. ~~Striving for the Perfect Care Experience~~
    b. Achieve bronze level Geriatric Emergency Department accreditation (GEDA)
    c. Strengthen access to care and provider capacity by reducing appointment delays and improving same day access
    d. Highlight standard work process improvement, utilizing improvement science principles, to improve quality, access, and efficiency
    e. Emphasis on health equity in order to attain the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes (Health equity | CMS).
    f. Identify and promote best practice and evidence-based medicine in every service line
    g. Focus on CMS quality ~~star~~Star rating improvements, within the measure groups~~,~~ that fall below benchmark
    h. ~~Highlight Management Systems and standard work process improvement, utilizing lean principles, to improve quality, access, and efficiency~~
    i. ~~Emphasis on health equity in order to attain the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes (Health equity | CMS).~~
    j. Improving care coordination and reducing avoidable readmissions and hospital transfers

2. ~~Continued focus on quality and patient/employee safety related to infectious diseases, following CDC, State, and County Health guidelines, and utilizing the following strategies:~~

~~a. Strengthen the system and environment~~
~~b. Support patient, family, and community engagement and empowerment~~
~~c. Improve clinical care~~
~~d. Reduce harm~~
~~e. Boost and expand the learning system~~Continued focus on quality and patient/ employee safety related to infectious diseases by adhering to State, County Health, and Federal requirements. These efforts will be supported through proactive prevention, early detection, rapid response, and ongoing education to protect patients, staff, and the wider community.

3. Ongoing survey readiness, and compliance with federal and state regulations, resulting in a successful triennial ~~General Acute~~Accreditation Commission for Health Care ~~Hospital Relicensing~~ (~~GACHLRS~~ACHC) ~~and Rural Health Clinic~~ re-accreditation survey
4. Sustain a culture of safety, transparency, accountability, and system improvement
    a. Continued participation in Beta HEART (Healing, Empathy, Accountability, Resolution, Trust) program
    b. Conduct annual Culture of Safety SCORE (Safety, Culture, Operational, Reliability, and Engagement) survey
    c. Continued focus on the importance of event reporting, including near misses
5. Focus on our culture of safety, across the entire Health System, utilizing High Reliability Organizational thinking
    a. Proactive, not reactive
    b. Focus on building a strong, resilient system
    c. Understand vulnerabilities
    d. Recognize bias
    e. Efficient resource management
    f. Evaluate system based on risk, not rules
6. Emphasis on achieving highly reliable health care through the following:
    a. A commitment to the goal of zero harm
    b. A safety culture, which ensures employees are comfortable reporting errors without fear of retaliation
    c. Incorporate highly effective process improvement tools and methodologies into our work flows
    d. Ensure that everyone is accountable for safety, quality, and patient experience
7. ~~Support Patient and Family Centered Care and the Patient and Family Advisory Council~~
    ~~a. Dignity and Respect: Health care practitioners listen to and honor patient~~

~~and family perspectives and choices. Patient and family knowledge, values, beliefs and cultural backgrounds are incorporated into the planning and delivery of care.~~

~~b. Information Sharing: Health care practitioners communicate and share complete and unbiased information with patients and families in ways that are affirming and useful. Patients and families receive timely, complete and accurate information in order to effectively participate in care and decision-making.~~

~~c. Participation: Patients and families are encouraged and supported in participating in care and decision-making at the level they choose.~~

~~d. Collaboration: Patients, families, health care practitioners, and health care leaders collaborate in policy and program development, implementation and evaluation; in research; in facility design; and in professional education, as well as in the delivery of care.~~

8. ~~Promote lean principles to improve processes, reduce waste, and eliminate inefficiencies~~
9. Integrate Patient and Family Centered Care principles to promote dignity, transparent communication, meaningful participation, and collaborative decision-making. Through engagement of patients, families, and the Patient and Family Advisory Council, the health system enhances care quality, safety, access, and the overall patient experience.
10. Identify areas for system improvement based on patient, family, and community input
11. Implement system-wide changes in strategy, structure, processes, culture, and leadership to adapt to external drivers such as market demands, technology advancements, and public health emergencies. Identified initiatives focus on improving employee engagement, performance, and innovation through structured change management, strong leadership alignment, and HR-supported transition planning to ensure sustainable, organization-wide improvement.
12. Utilize improvement science principles to streamline work-flows, reduce waste, improve efficiency, and enhance patient-centered care through continuous performance improvement.
13. Maximize Epic reporting functionality to ~~improve~~enhance data capture ~~and identification of areas for~~, strengthen clinical and operational visibility, and more effectively identify opportunities for quality improvement.
14. ~~Develop an enterprise wide data governance strategy~~Develop an enterprise-wide data clinical governance, and Business Intelligence strategy to ensure consistent data standards, improve data quality, support regulatory compliance, and strengthen organizational decision-making.

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

ORGANIZATION FRAMEWORK

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

Governing Board

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

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

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

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

D. The Board:

    1. Delegates the authority for developing, implementing, and maintaining performance improvement activities to Administration, Medical Staff, Management, and employees;
    2. Responsible for determining, implementing, and monitoring policies governing the Critical Access Hospital (CAH) and Rural Health Clinic (RHC) total operation and for ensuring that those policies are administered so as to provide quality health care in a safe environment (CMS 485.627(a))
    3. Recognizes that performance improvement is a continuous, never-ending process, and therefore they will provide the necessary resources to carry out this philosophy;
    4. Provides direction for the organization's improvement activities through the development of strategic initiatives;
    5. Evaluates the organization's effectiveness in improving quality through reports from Administration, Department Directors, Medical Executive Committee, and Medical Staff Quality Committee.

Administrative Council

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

B. Administrative Council ensures that clinical contracts contain quality performance indicators to measure the level of care and service provided.

C. Administrative Council has developed a culture of safety by embracing High Reliability tenets and has set behavior expectations for providing Safe, Timely, Effective, Efficient, Equitable, Patient Centered Care (STEEEP™), supporting Triple Aim, and ensures compliance with regulatory, statutory, and contractual requirements.

Board Quality Committee

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

Medical Executive Committee

A. The Medical Executive Committee shares responsibility with the BOD Quality Committee, and the Administrative Council, for the ongoing quality of care and services provided within the Health System.

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

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

Department Chairs of the Medical Staff

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

Medical Staff

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

Hospital Management (Directors, Managers, and Supervisors)

A. Management is responsible for ongoing performance improvement activities in their departments and for supporting teams chartered by the Medical Staff Quality Committee. Many of these activities will interface with other departments and the Medical Staff. They are expected to do the following:
    1. Foster an environment of collaboration and open communication with both internal and external customers;
    2. Participate and guide staff to focus on patient safety, patient and family centered care, service recovery, and patient satisfaction;
    3. Advance the philosophy of High Reliability within their departments;
    4. Utilize Lean principles and DMAIC (Define, Measure, Analyze, Improve, Control) process improvement activities for department-specific performance improvement initiatives;

5. Establish performance and patient safety improvement activities in conjunction with other departments;
6. Encourage staff to report any and all reportable events including "near-misses";
7. Participate in the investigation and determination of the causes that underlie a "near-miss" / Sentinel/Adverse Event/Error or Unanticipated Outcome and implement changes to reduce the probability of such events in the future.

Employees

A. The role of the individual employee is critical to the success of a performance improvement initiative. Quality is everyone's responsibility and each employee is charged with practicing, and supporting, the *Code of Conduct* (ACMP-1901), and *Chain of Command for Medical Plan of Care* (ANS-1404) policies. All employees must feel empowered to report, correct, and prevent problems.

B. The multidisciplinary Patient Safety Committee consists of staff from each service area. This Committee will assist with quality, patient safety, patient experience, and infection prevention. They will evaluate processes, provide recommendations, identify process improvement opportunities, and communicate their findings with peers to improve practice across the Health System.

C. The multidisciplinary Patient Experience Committee consists of staff from each service area. The Committee will assist with patient satisfaction, and service excellence. They will evaluate processes, provide recommendations, identify process improvement opportunities, and communicate their findings with peers to improve service excellence across the Health System.

D. Employees are expected to do the following:
    1. Contribute to improvement efforts, including reporting Sentinel/Adverse Event/Error or Unanticipated Outcomes, to produce positive outcomes for the patient and ensure the perfect care experience for patients and customers;
    2. Make suggestions/recommendations for opportunities of improvement or for a cross-functional team, including risk reduction recommendations and suggestions for improving patient safety, by contacting their Director or Manager, the Director of Quality and Regulations, the Medical Director of Quality, or an Administrative Council Member.

PERFORMANCE IMPROVEMENT STRUCTURE

Medical Staff Quality Assessment Committee

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

are held at least quarterly each year.

The Medical Staff Quality Assessment Committee:

A. Annually review and approve the *Quality Assurance Performance Improvement Plan* (AQPI-05), *Medication Error Reduction Plan* (APH-34), *Medication Error Reporting* (APH-24), *Infection Control Plan* (AIPC-64), *Environment of Care Management Program* (AEOC-98), *Emergency Operations Plan* (AEOC-17), *Utilization Review Plan* (DCM-1701), *Discharge Plan* (ANS-238), *Risk Management Patient Safety Plan* (AQPI-04), *Employee Health Plan* (DEH-39), *Trauma Performance Improvement Plan*, *Home Health Quality Plan* (DHH-1802), and the *Hospice Quality Plan* (DHOS-1801).

B. Regularly reviews progress to the aforementioned plans;

C. Reviews quality indicator reports to evaluate patient care, and the delivery of services, and takes appropriate actions based on patient and process outcomes;

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

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

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

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

H. Reviews summaries and recommendations of Event Analysis/Root Cause Analysis (RCA) and Failure Mode Effects Analysis (FMEA) activities;

I. Oversees the radiation safety program, including nuclear medicine and radiation oncology, and evaluates the services provided and makes recommendations to the MEC;

J. Oversees the Infection Control, Pharmacy & Therapeutics, and Antibiotic Stewardship program and monitors compliance with their respective plans;

K. Oversees the multidisciplinary Cancer Committee and monitors compliance with the Cancer Center quality plan;

L. Oversees the Trauma Program and monitors compliance with the Trauma Performance Improvement plan~~.~~;

M. Oversees the Stroke Program and monitors compliance with the Stroke QA/PI plan;

N. Oversees the Interdisciplinary Practice Committee (AQPI-2401) and RN standardized procedure approvals.

Performance Improvement Committee (PIC)

A. Medical Staff Quality Assessment Committee provides direct oversight for the PIC. PIC is an executive committee with departmental representatives within the Tahoe Forest Health

System, presenting their QA/PI findings as assigned. The goal of this committee is to achieve optimal patient outcomes by making sure that all staff participate in performance improvement activities. Departmental Directors, or their designee, review assigned quality metrics annually at the PIC (See Attachment C – QA PI Reporting Measures). Performance improvement includes collecting data, analyzing the data, and taking action to improve. Director of Quality and Regulations is responsible for processes related to this Committee.

B. The Performance Improvement Committee will:
    1. Oversee the Performance Improvement activities including data collection, data analysis, improvement, and communication to stakeholders;
    2. Set performance improvement priorities that focus on high-risk, high volume, or problem prone areas;
    3. Guide the department to and/or provide the resources to achieve improvement;
    4. Reviews requests for chartered Performance Improvement Teams. Requests for teams may come from committees, department or individual employees. Not all performance improvement efforts require a chartered team;
    5. Report the committee's activities quarterly to the Medical Staff Quality Committee.

SCIENTIFIC METHOD FOR IMPROVEMENT ACTIVITIES

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

Performance Improvement Teams

A. Teams are cross-functional and multidisciplinary in nature. The priority and type of team are based on the strategic initiatives of the organization, with regard to high risk, high volume, problem prone, and low volume.

B. Performance Improvement Teams will:
    1. Follow the approved team charter as defined by the Administrative Council Members, or MS QAC
    2. Establish specific, measurable goals and monitoring for identified initiatives
    3. Utilize lean principles to improve processes, reduce waste, and eliminate inefficiencies
    4. Report their findings and recommendations to key stakeholders, PIC, and the MS QAC.

PERFORMANCE IMPROVEMENT EDUCATION

A. Training and education are essential to promote a culture of quality within the Tahoe Forest Health System. All employees and Medical Staff receive education about performance

improvement upon initial orientation. Employees and Medical Staff receive additional training on various topics related to performance improvement.

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

C. DMAIC (Define, Measure, Analyze, Improve, Control):
a. Define: identify the problem and project goals
b. Measure: collect data to understand current performance
c. Analyze: identify root causes of defects and issues
d. Improve: develop and implement solutions to address root causes
e. Control: monitor the improvement to sustain gains and ensure consistent performance

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

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

PERFORMANCE IMPROVEMENT PRIORITIES

A. The QA PI program is an ongoing, data driven program that demonstrates measurable improvement in patient health outcomes, improves patient safety by using quality indicators or performance improvement measures associated with improved health outcomes, and by the identification and reduction of medical errors.

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

1. Processes that are high risk, high volume, or problem prone areas with a focus on the incidence, prevalence, and severity of problems in those areas
2. Processes that affect health outcomes, patient safety, and quality of care
3. Processes related to patient advocacy and the perfect care experience
4. Processes related to the Critical Access Hospital (CAH) National Patient Safety Goals (NPSGs)
5. Processes related to patient flow
6. Processes associated with near miss Sentinel/Adverse Event/Error or Unanticipated Outcome

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

1. Identified needs from data collection and analysis
2. Unanticipated adverse occurrences affecting patients
3. Processes identified as error prone or high risk regarding patient safety
4. Processes identified by proactive risk assessment
5. Changing regulatory requirements
6. Significant needs of patients and/or staff
7. Changes in the environment of care
8. Changes in the community

DESIGNING NEW AND MODIFIED PROCESSES/FUNCTIONS/ SERVICES

A. Tahoe Forest Health System designs and modifies processes, functions, and services with quality in mind. When designing or modifying a new process the following steps are taken:
    1. Key individuals, who will own the process when it is completed, are assigned to a team led by the responsible individual.
    2. An external consultant is utilized to provide technical support, when needed.
    3. The design team develops or modifies the process utilizing information from the following concepts:
        a. It is consistent with our mission, vision, values, and strategic priorities and meets the needs of individual served, staff and others
        b. It is clinically sound and current
        c. Current knowledge when available and relevant, i.e., practice guidelines, successful practices, information from relevant literature and clinical standards
        d. It is consistent with sound business practices
        e. It incorporates available information and/or literature from within the organization and from other organizations about potential risks to patients, including the occurrence of sentinel/near-miss events, in order to minimize risks to patients affected by the new or redesigned process, function, or service
        f. Conducts an analysis, and/or pilot testing, to determine whether the proposed design/redesign is an improvement and implements performance improvement activities, based on this pilot
        g. Incorporates the results of:
            i. performance improvement activities
            ii. consideration of staffing effectiveness
            iii. consideration of patient safety issues
            iv. consideration of patient flow issues

4. Performance expectations are established, measured, and monitored. These measures may be developed internally or may be selected from an external system or source. The measures are selected utilizing the following criteria:
    a. identify the events it is intended to identify
    b. a documented numerator and denominator or description of the population to which it is applicable
    c. defined data elements and allowable values
    d. detect changes in performance over time
    e. allow for comparison over time within the organization and between other entities
    f. data to be collected is available
    g. results can be reported in a way that is useful to the organization and other interested stakeholders

B. An individual with the appropriate expertise within the organization is assigned the responsibility of developing the new process.

PROACTIVE RISK ASSESSMENTS

A. Risk assessments are conducted to pro-actively evaluate the impact of buildings, grounds, equipment, occupants, and internal physical systems on patient and public safety. This includes, but is not limited to, the following:
    1. A Failure Mode and Effect Analysis (FMEA) will be completed based on the organization's assessment and current trends in the health care industry, and as approved by PIC or the MS QAC.
    2. The Medical Staff Quality Committee, and other leadership committees, will recommend the processes chosen for proactive risk assessments based on literature, errors and near miss events, sentinel event alerts, and the CAH National Patient Safety Goals (NPSGs).
        a. The process is assessed to identify steps that may cause undesirable variations, or “failure modes”.
        b. For each identified failure mode, the possible effects, including the seriousness of the effects on the patient are identified and the potential breakdowns for failures will be prioritized.
        c. Potential risk points in the process will be closely analyzed, including decision points and patient’s moving from one level of care to another through the continuum of care.
        d. For the effects on the patient that are determined to be “critical”, an event analysis/root cause analysis is conducted to determine why the effect may occur.
        e. The process will then be redesigned to reduce the risk of these failure modes occurring or to protect the patient from the effects of the failure

modes.

f. The redesigned process will be tested and then implemented. Performance measurements will be developed to measure the effectiveness of the new process.

g. Strategies for maintaining the effectiveness of the redesigned process over time will be implemented.

3. Ongoing hazard surveillance rounds, including Environment of Care Rounds, and departmental safety hazard inspections, are conducted to identify any trends and to provide a comprehensive ongoing surveillance program.
4. The Environment of Care Safety Officer and EOC/Safety Committee review trends and incidents related to the Safety Management Plans. The EOC Safety Committee provides guidance to all departments regarding safety issues.
5. The Infection Preventionist, and Environment of Care Safety Officer, or designee, complete a written infection control and pre-construction risk assessment for interim life safety for new construction or renovation projects.

DATA COLLECTION

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

1. Medication therapy
2. Adverse event reports
3. National patient safety goals
4. Infection control surveillance and reporting
5. Surgical/invasive and manipulative procedures
6. Blood product usage, including transfusions and transfusion reactions
7. Data management
8. Discharge planning
9. Utilization management
10. Complaints and grievances
11. Restraints/seclusion use
12. Mortality review
13. Medical errors including medication, surgical, and diagnostic errors; equipment failures, infections, blood transfusion related injuries, and deaths due to seclusion or restraints
14. Needs, expectations, and satisfaction of individuals and organizations served, including:

a. Their specific needs and expectations
b. Their perceptions of how well the organization meets these needs and expectations
c. How the organization can improve patient safety
d. The effectiveness of pain management

15. Resuscitation and critical incident debriefings
16. Unplanned patient transfers/admissions
17. Medical record reviews
18. Performance measures from acceptable data bases/comparative reports, i.e., RL Datix Event Reporting, QCentrix, NDNQI, HCAHPS, Care Compare, QualityNet, HSAG HIIN, MBQIP, HCAI, and Press Ganey, etc.
19. Summaries of performance improvement actions and actions to reduce risks to patients

B. In addition, the following clinical and administrative data is aggregated and analyzed to support patient care and operations:
    1. Quality measures delineated in clinical contracts will be reviewed annually
    2. Pharmacy transactions as required by law and to control and account for all drugs
    3. Information about hazards and safety practices used to identify safety management issues to be addressed by the organization
    4. Records of radionucleotides and radiopharmaceuticals, including the radionucleotide's identity, the date received, method of receipt, activity, recipient's identity, date administered, and disposal
    5. Reports of required reporting to federal, state, authorities
    6. Performance measures of processes and outcomes, including measures outlined in clinical contracts

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

AGGREGATION AND ANALYSIS OF DATA

A. Tahoe Forest Health System believes that excellent data management, and analysis, are essential to an effective performance improvement initiative. Statistical tools are used to analyze and display data. These tools consist of dashboards, bar graphs, pie charts, run charts (SPC), histograms, Pareto charts, control charts, fishbone diagrams, and other tools as appropriate.

B. All performance improvement teams and activities must be data driven and outcome based. The analysis includes comparing data within our organization, with other comparable organizations, with published regulatory standards and benchmarks, and best practices. Data is aggregated and analyzed within a time frame appropriate to the process or area of study. Data will also be analyzed to identify system changes that will help improve patient safety and

promote a perfect care experience (See Attachment D for QI PI Indicator definitions).

C. The data is used to monitor the effectiveness and safety of services, and quality of care. The data analysis identifies opportunities for process improvement, and changes in patient care processes. Adverse patient events are analyzed to identify the cause, implement process improvement and preventative strategies, and ensure that improvements are sustained over time.

D. Data is analyzed in many ways including:
    1. Using appropriate performance improvement problem solving tools
    2. Making internal comparisons of the performance of processes and outcomes over time
    3. Comparing performance data about the processes with information from up-to-date sources
    4. Comparing performance data about the processes and outcomes to other hospitals, benchmarks, and reference databases

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

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

REPORTING

A. Results of the outcomes of performance improvement and patient safety activities identified through data collection and analysis, performed by Medical Staff, ancillary, and nursing services, in addition to outcomes of performance improvement teams, will be reported to the MS QAC at a minumum of annually.

B. Results of the appraisal of performance measures outlined in clinical contracts will be reported to the MS QAC at a minimum of annually.

C. The MS QAC will provide their analysis of the quality of patient care and services to the Medical Executive Committee regularly.

D. The Medical Executive Committee, Quality Medical Director, or the Director of Quality & Regulations will report to the BOD regularly relevant findings from all performance improvement activities performed throughout the System.

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

CONFIDENTIALITY AND CONFLICT OF INTEREST

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

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

ANNUAL ASSESSMENT

A. The Critical Access Hospital (CAH), and Rural Health Clinic (RHC), Quality Assessment Performance Improvement (QA PI) program, and the objective, structure, methodologies, and results of performance improvement activities will be evaluated at least annually (CMS485.641(b)(1)).

B. The evaluation includes a review of patient care and patient related services, infection control, medication administration, medical care, and the Medical Staff. More specifically, the evaluation includes a review of the utilization of services (including at least the number of patients served and volume of services), chart review (a representative sample of both active and closed clinical records), and the Health System policies addressing provision of services. Refer to *Available CAH Services* (AGOV-06) policy.

C. The purpose of the evaluation is to determine whether the utilization of services is appropriate, policies are followed, and needed changes are identified. The findings of the evaluation and corrective actions, if necessary, are reviewed. The Quality Assessment program evaluates the quality and appropriateness of diagnoses, treatments furnished, and treatment outcomes.

D. An annual report summarizing the improvement activities, and the assessment, will be submitted to the Medical Staff Quality Committee, the Medical Executive Committee, and the Board of Directors.

PLAN APPROVAL

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

Related Policies/Forms:

Available CAH Services, TFH & IVCH, AGOV-06

Medication Error Reduction Plan, APH-34

Medication Error Reporting, APH-24

Infection Control Plan, AIPC-64

Environment of Care Management Program, AEOC-908

Utilization Review Plan (UR), DCM-1701

Risk Management and Patient Safety Plan, AQPI-02

Emergency Operations Plan (Comprehensive), AEOC-17

Discharge Planning, ANS-238

Employee Health Plan, DEH-39

Quality Assurance and Performance Improvement Program, DHH-1802

Quality Assurance and Performance Improvement Program, DHOS-1801

References:

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

Attachments

A. Quality Initiatives 2026.docx

B. QA PI Reporting Matrix 2026.xlsx

C. QI Indicator Definitions 2026.docx

D. External Reporting 2026.docx

E. Quality Reporting Programs 2026.xlsx

Approval Signatures

Step Description	Approver	Date

TAHOE FOREST
HOSPITAL DISTRICT

AGENDA ITEM COVER SHEET

MEETING DATE: March 26, 2026	**ITEM:** Board Charters
DEPARTMENT: Board of Directors	**TYPE OF AGENDA ITEM:** ☐ Action ☒ Consent ☐ Discussion
RESPONSIBLE PARTY: Sarah Jackson, Clerk of the Board	**SUPPORTIVE DOCUMENT ATTACHED** ☐ Agreement ☐ Presentation ☐ Resolution ☒ Other **Committee Charters**
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:
Each Board Committee will annually review and recommend for approval the Committee Charter with changes as needed.

SUMMARY/OBJECTIVES:
Board Executive Compensation Committee Charter
Committee reviewed the charter on March 16, 2026. Committee recommends no changes to the Charter for 2026.

SUGGESTED DISCUSSION POINTS:
None

SUGGESTED MOTION/ALTERNATIVES:
Move to approve the Board Executive Compensation Committee Charters with no changes as presented.
(includes all consent items)

Alternate: Pull the Board Executive Compensation Committee Charters from consent for further discussion under section 16.

LIST OF ATTACHMENTS:
Board Executive Compensation Committee Charter – FINAL from May 2025

Charter

Executive Compensation Committee
(formerly Personnel Committee)
Tahoe Forest Hospital District
Board of Directors

PURPOSE:

The purpose of the charter is to delineate the responsibilities and duties of the Executive Compensation Committee of the District's Board of Directors.

RESPONSIBILITIES:

The Executive Compensation Committee is responsible for assisting the Board in oversight of President & Chief Executive Officer (CEO) relations and the work done through the Winning Aspirations.

DUTIES:

1. Oversee the identification and recruitment of the organization's CEO as directed by the Board of Directors.
2. Ensure an annual CEO performance evaluation process is in place.
3. In conjunction with the CEO, using a standardized evaluation tool, annually review and recommend modifications of the goals and objectives documents which will be used to evaluate the performance of the CEO.
4. Review annually the CEO's comprehensive compensation package, and make recommendations to the Board of Directors as necessary.
5. Review metrics annually for the CEO's Incentive Compensation Criteria and make recommendations to the Board of Directors as necessary.
6. Review annually the CEO's Employment Agreement, and make recommendations to the Board of Directors as necessary.
7. In conjunction with the CEO, review and evaluate annually the CEO position description to ensure its continued relevance. Recommend revisions to the Board of Directors as necessary.

COMPOSITION:

The Committee is comprised of at least two (2) board members appointed by the Board Chair.

MEETING FREQUENCY:

The Committee shall meet at least once annually and then on an as needed basis.

Approved by Board of Directors 06/27/2024
No changes-Approved by Board of Directors 05/22/2025

TAHOE FOREST
HOSPITAL DISTRICT

AGENDA ITEM COVER SHEET

MEETING DATE: March 9, 2026	**ITEM:** Ratify TFHS Foundation Board Member
DEPARTMENT: TFHS Foundation	**TYPE OF AGENDA ITEM:** ☐ Action ☒ Consent ☐ Discussion
RESPONSIBLE PARTY: Karli Bunnell, Executive Director of Foundations	**SUPPORTIVE DOCUMENT ATTACHED** ☐ Agreement ☐ Presentation ☐ Resolution ☒ Other **Resume & Request Letter**
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: The Tahoe Forest Health System Foundation's Board of Directors have approved the addition of a new board member, Lynne Weakley. Lynne brings positive energy and a collaborative spirit that will further strengthen board engagement. Her family's longstanding charitable support of the Foundation provides a valuable perspective to include at the board level. Lynne also has a meaningful connection to the Gene Upshaw Memorial Cancer Center, allowing her to offer thoughtful insight into the patient care experience. Combined with her deep commitment to the Foundation's mission, she will be a wonderful addition as we continue to advance our work and strategic priorities.

SUMMARY/OBJECTIVES: The Tahoe Forest Health System Foundation's Board of Directors respectfully requests approval from the District Board of Directors to appoint an additional board member.

SUGGESTED DISCUSSION POINTS: N/A

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

LIST OF ATTACHMENTS: Bio

TAHOE FOREST
HEALTH SYSTEM FOUNDATION

Date: March 9, 2026

To: Tahoe Forest Hospital District Board of Directors

From: Karli Bunnell, Executive Director – Tahoe Forest Health System Foundation

Re: Request for new board member approval

Dear Tahoe Forest Hospital District:

TFHSF has recently approved Lynne Weakley to become a board member. She brings a wealth of experience, expertise, and community connections to our Foundation Board and community.

Lynne Weakley's bio is attached.

Respectfully submitted on behalf of the Tahoe Forest Health System Foundation.

Lynne Weakley received a Bachelor of Science degree from the University of Nevada Reno in 1977. The degree included a multi-subject credential for grades one through twelve. After graduation, she was a substitute teacher at Verdi Elementary in Nevada, followed by a year-long-term substitute position. During this time, her husband Ken started Mountain Electric, Inc., an electrical contracting company in Truckee. Lynne was in the position of office manager/bookkeeper for the following 30 years. She was a board member and served as president in the Home Owners Association (HOA) Board in Ketchum, Idaho for 8 years. Lynne loves to hike and cross-country ski in the Sierra Nevada mountains. She raised three children in Truckee, all who attended and graduated from local schools.

TAHOE FOREST
HEALTH SYSTEM

TAHOE FOREST ORTHOPEDICS & SPORTS MEDICINE

EXCEPTIONAL CARE BEGINS HERE

Athletic Training Outreach Program

Anna Aldridge, MS, MBA, LAT, ATC

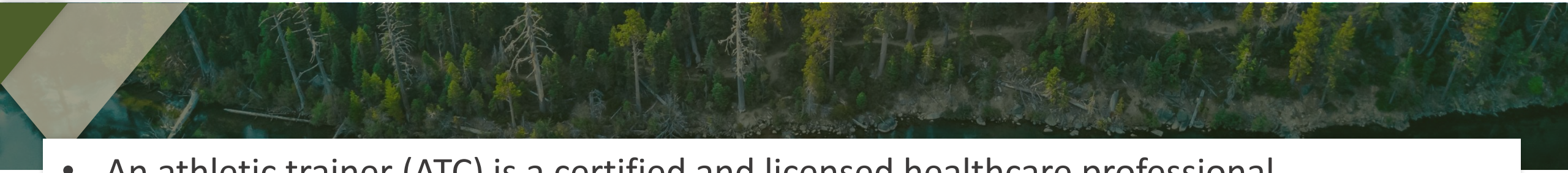
Manager of Sports Medicine

INTRODUCTION

- **Our Outreach Goal:** Help the community by providing on-site care, and fast-tracking and simplifying access to care with the help of Certified Athletic Trainers (ATCs).
- Who our program reaches:
  - Student-Athletes and their families
  - Students
  - Administrators, coaches, and their families

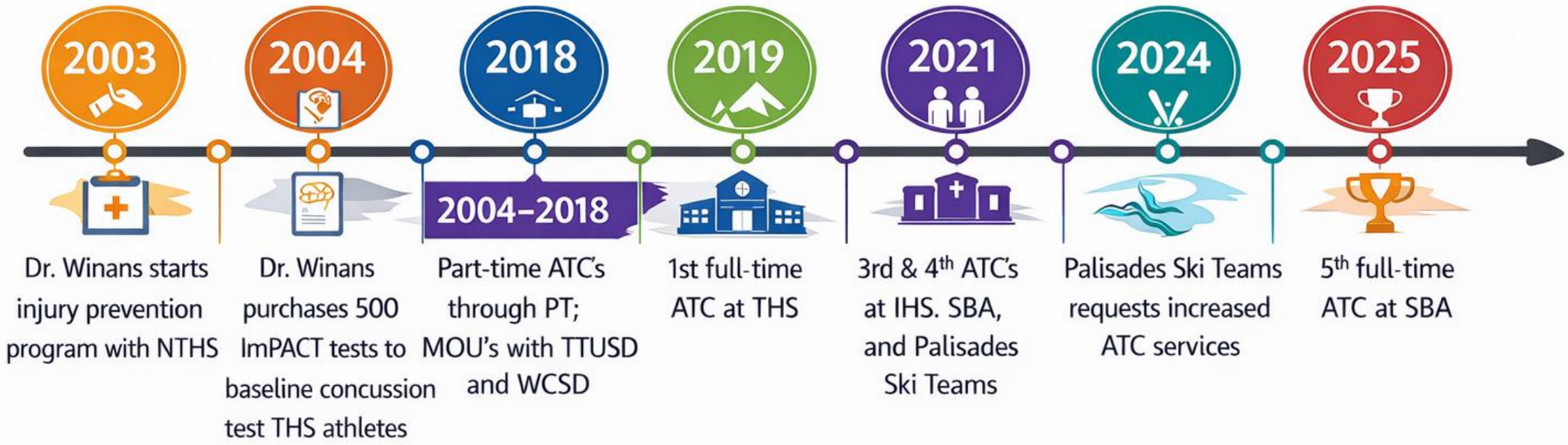
TAHOE FOREST HEALTH SYSTEM

WHAT IS AN ATHLETIC TRAINER?



- An athletic trainer (ATC) is a certified and licensed healthcare professional.
- Services provided by ATCs include:
  - Injury prevention
  - Emergency care
  - Clinical diagnosis
  - Therapeutic intervention and rehabilitation
- ATCs are often one of the most trusted health care providers for those they work with.
  - Through the TTUSD Caring Connections survey, the ATCs are often named one of the most trusted staff members.
- ATCs work under the supervision of physicians

HISTORY OF THE PROGRAM



TAHOE FOREST HEALTH SYSTEM

PARTNERSHIPS

Washoe County School District

TAHOE TRUCKEE UNIFIED SCHOOL DISTRICT
PATHWAYS TO POSSIBILITIES AND STUDENT SUCCESS

Team PALISADES TAHOE

SugarBowl Academy

WOOD WARD TAHOE / CA

TAHOE FOREST HEALTH SYSTEM

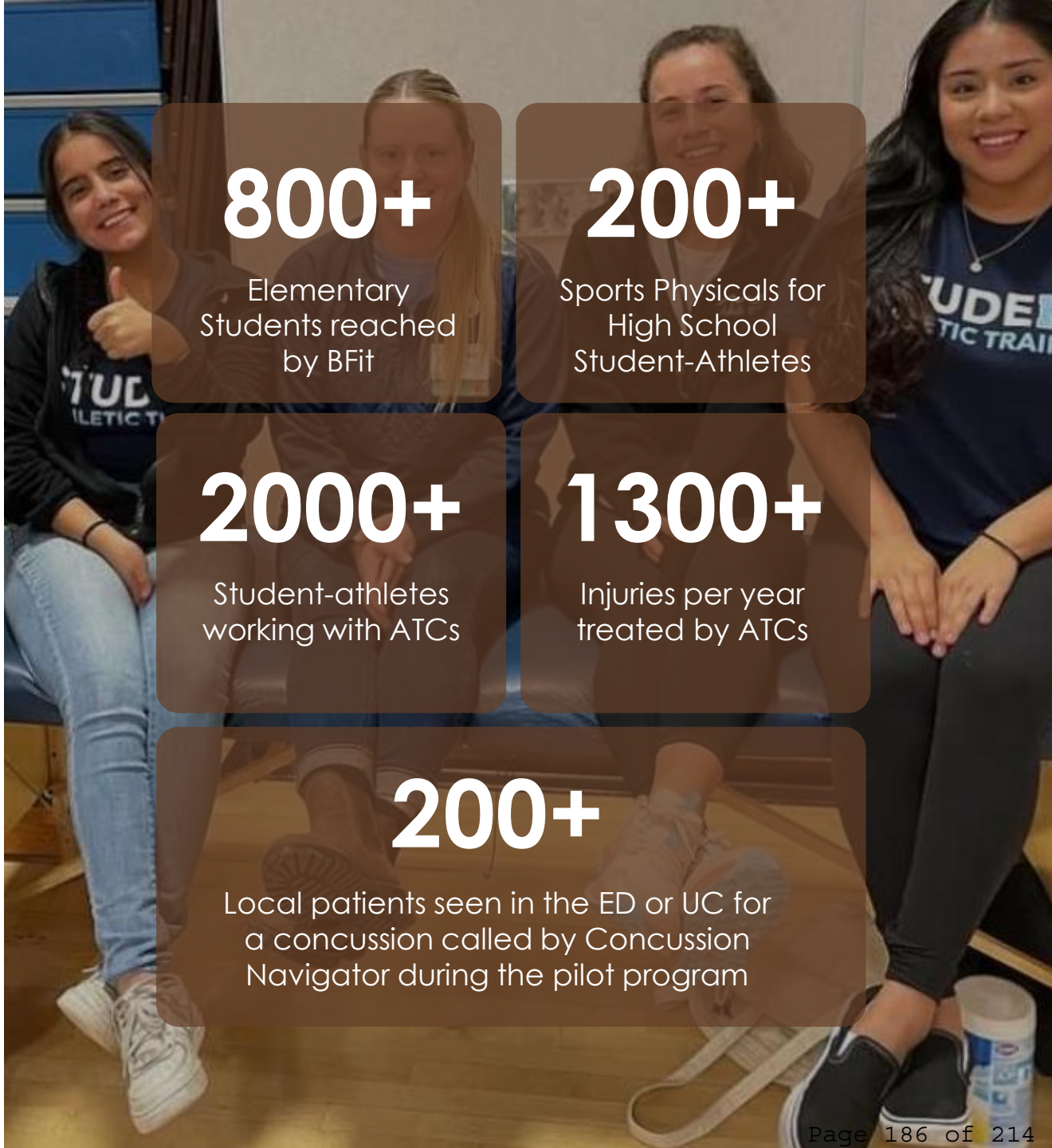
Truckee Wolverines

Community

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

COLLECTIVELY

- Injury reduction testing and programming
- Baseline and post-injury concussion testing
- BFit
- Concussion Navigation
- Community Education
- Sports Physicals for the community



TAHOE FOREST HEALTH SYSTEM

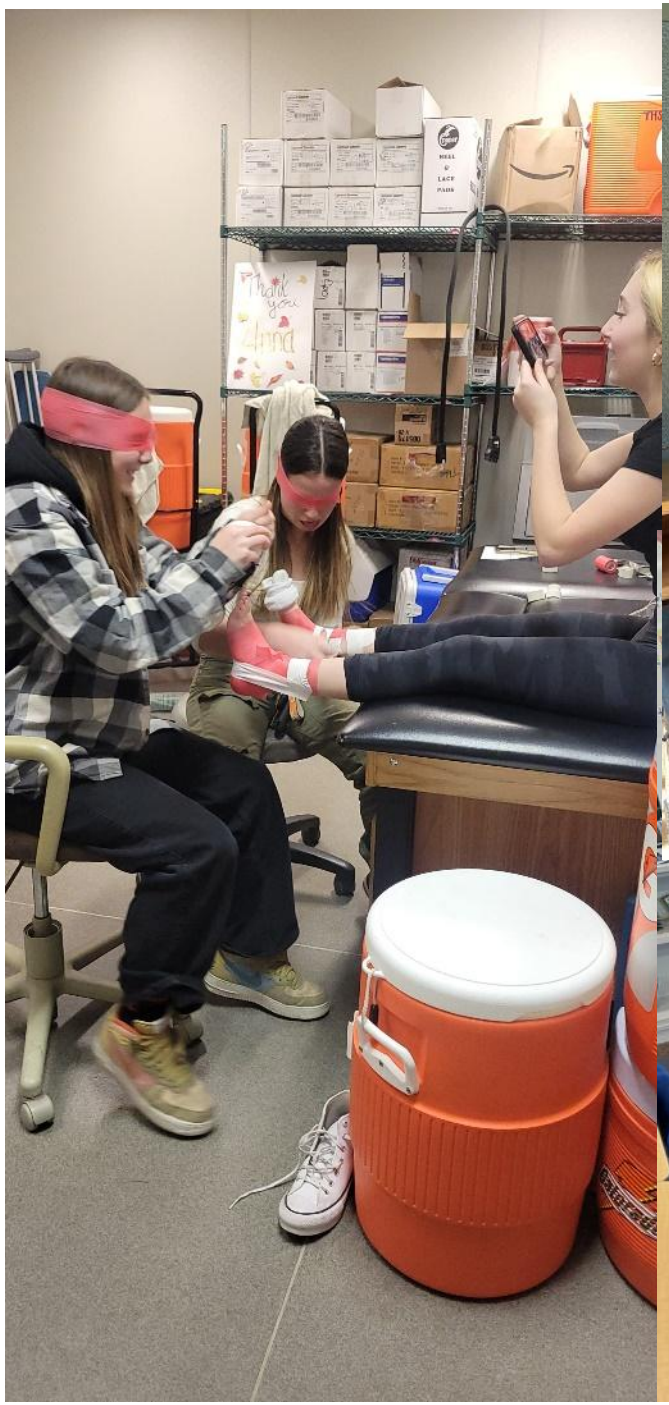
179 likes

northtahoehs NTHS's first ever student athletic trainers from Sports Med 2 in ACTION!!!!

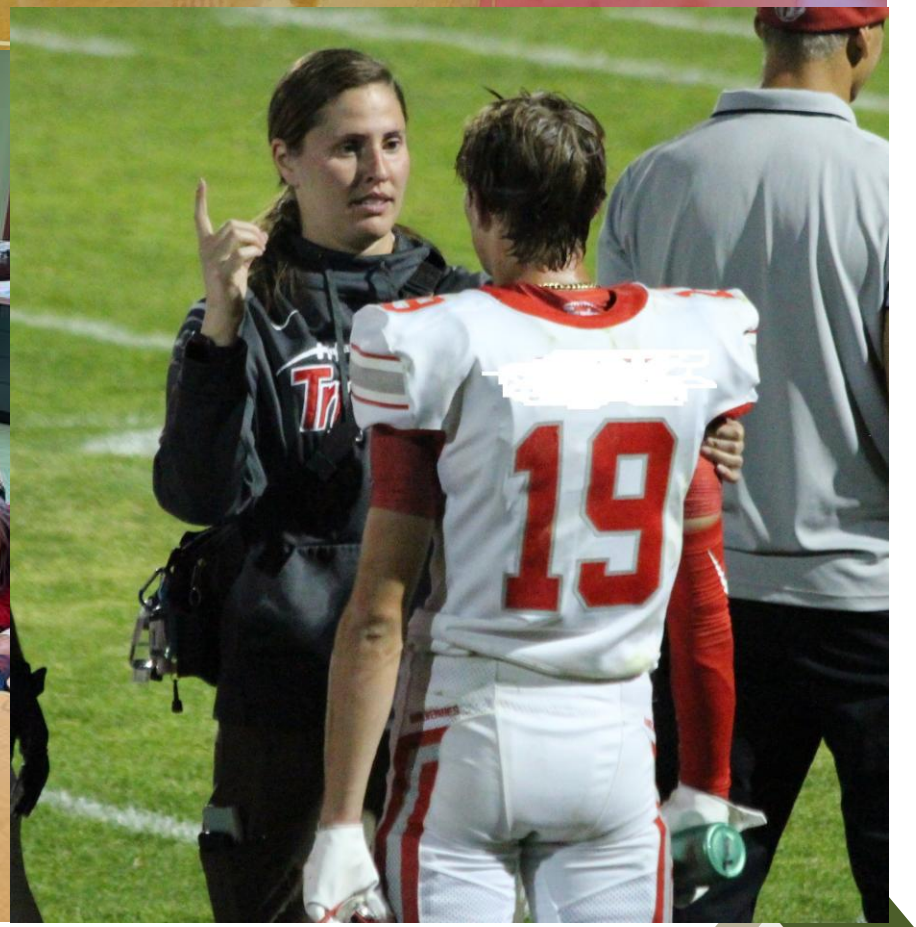
truckee_football

Liked by **ashley_jean_** and **270 others**

truckee_football Truckee Football wants to give a HUGE shoutout to @anna.aldridge17 for always being there for our athletes. Today his her last day at Truckee High. Thanks Anna! #wolverines #truckeepride #truckeefootball #RedDawn


Thank you
4mnd


WOLVERINES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northtahoehs


TRUCKEE
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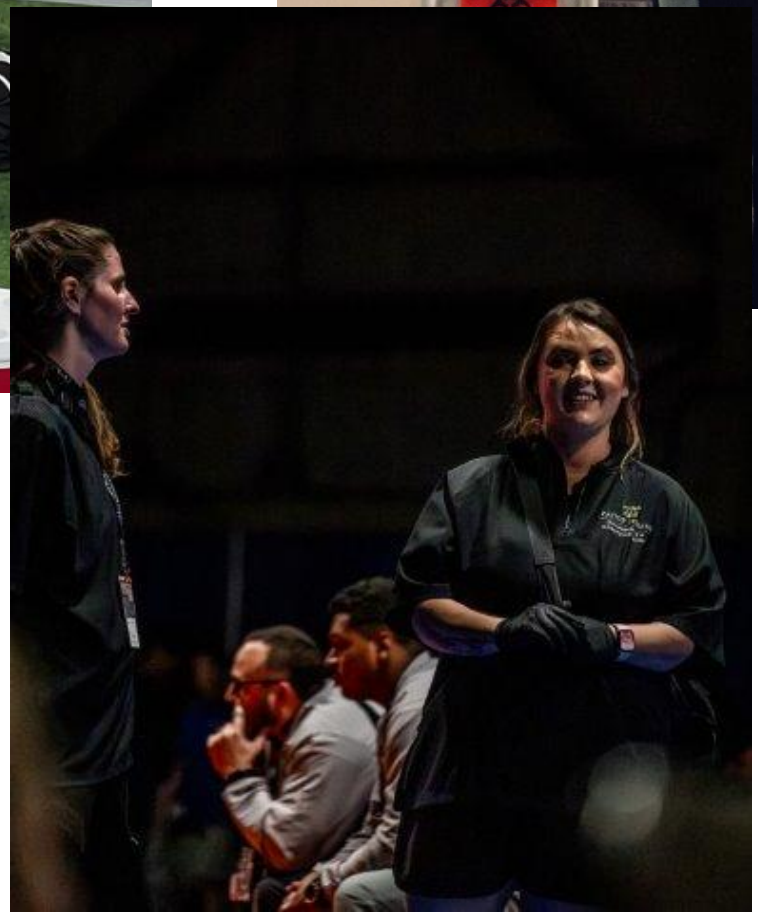
GATORADE



CONCLUSION

- Our strategic plan includes expanding our community presence by providing quality care with current and future partnerships.
  - Lacrosse
  - Truckee River United Soccer
  - OVFFT
  - Middle Schools

TAHOE FOREST HEALTH SYSTEM

Questions?

www.tahoeorthopedicsandsports.com

aaldridge@tfhd.com

(530) 448-4283

TAHOE FOREST
HEALTH SYSTEM

TAHOE FOREST
HOSPITAL DISTRICT

AGENDA ITEM COVER SHEET

MEETING DATE: March 26, 2026	**ITEM:** 16.1. Disruption of Telephonic or Internet Service during Public Meetings, ABD-2601
DEPARTMENT: Administration	**TYPE OF AGENDA ITEM:** ☒ Action ☐ Consent ☐ Discussion
RESPONSIBLE PARTY: Sarah Jackson, Clerk of the Board	**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:
Administrative and departmental operating policies must be reviewed *at least once every three years*, more often as necessary.

ABD-2601 is a new policy describing the Board of Directors procedures if there is a disruption of telephone or internet service during a District Board Meeting.

SUMMARY/OBJECTIVES:
Requires each eligible legislative body to adopt, by July 1, 2026, a publicly approved policy to address procedures when disruption of telephone or internet service occurs. The policy must provide for recessing, reconvening, and the efforts that the body shall make to attempt to restore service.

The policy cannot be adopted on the consent calendar.

SUGGESTED DISCUSSION POINTS:
The purpose of this policy is to comply with SB707 Brown Act

Reviewed by Governance Committee 3/11/2026, edits recommended by General Counsel.

SUGGESTED MOTION/ALTERNATIVES:
Move to recommend approval of ABD-2601 as presented.

Alternative Motion – recommend changes to ABD-2601 (if changes are recommended in discussion).

LIST OF ATTACHMENTS:
Disruption of Telephonic or Internet Service during Public Meetings, ABD-2601 (draft new policy)

Status **Pending** PolicyStat ID **19717454**

Origination Date	N/A
Last Approved	N/A
Last Revised	N/A
Next Review	3 years after approval
Department	Board - ABD
Applicabilities	System

Disruption of Telephonic or Internet Service During Public Meetings, ABD-2601

RISK:

Disruptions to telephonic or internet services can prevent the public from accessing or participating in meetings as required by the Brown Act, creating risks of noncompliance, reduced transparency, and interrupted proceedings.

POLICY:

~~Senate Bill 707 (2025) amended the Brown Act to require eligible legislative bodies to adopt, on or before July 1, 2026, a policy addressing how the agency will respond to disruptions in telephonic or internet service that prevent members of the public from attending or observing a meeting remotely. This policy is adopted to comply with that requirement and to ensure continuity of public participation during technical disruptions.~~

~~This policy establishes procedures for responding to a disruption in the telephonic or internet services that provide two-way remote public access to meetings of the **Tahoe Forest Hospital District (TFHD) Board of Directors**, as required by the Brown Act (Gov. Code § 54953.4). The policy ensures transparency, public participation, and continuity of government during technology disruptions.~~

~~**Definitions**~~

~~For purposes of this policy:~~

- ~~"Disruption" means any failure, outage, or other interruption that prevents members of the public from attending or observing the meeting via these remote access services.~~
- ~~"Remote access services" means the two-way telephonic service and/or two-way audiovisual~~

~~platform used to provide real-time remote public attendance and observation of meetings.~~

~~**Applicability**~~

~~This policy applies to all open and public meetings of the **TFHD Board of Directors** at which remote public participation is offered or required under the Brown Act.~~

A. Senate Bill 707 (2025) amended the Brown Act to require eligible legislative bodies to adopt, on or before July 1, 2026, a policy addressing how the agency will respond to disruptions in telephonic or internet service that prevent members of the public from attending or observing a meeting remotely. This policy is adopted to comply with that requirement and to ensure continuity of public participation during technical disruptions.

B. This policy establishes procedures for responding to a disruption in the telephonic or internet services that provide two-way remote public access to meetings of the **Tahoe Forest Hospital District (TFHD) Board of Directors**, as required by the Brown Act (Gov. Code § 54953.4). The policy ensures transparency, public participation, and continuity of government during technology disruptions.

Definitions:

A. For purposes of this policy:

1. "Service Disruption" means any failure, outage, or other interruptions to TFHD's remote access services that prevents members of the public from attending or observing the meeting via these remote access services.
2. "Remote access services" means the two-way telephonic service and/or two-way audiovisual platform used to provide real-time remote public attendance and observation of meetings.

Applicability:

A. This policy applies to all open and public meetings of the **TFHD Board of Directors** at which remote public participation is offered or required under the Brown Act. Consistent with the Brown Act, this policy shall not apply to the following meetings:

1. Meetings held to attend a judicial or administrative proceeding to which TFHD is a party.
2. Meetings held to inspect real or personal property provided that the topic of the meeting is limited to items directly related to the real or personal property.
3. Meetings held to meet with elected or appointed officials of the United States or the State of California, solely to discuss a legislative or regulatory issue affecting TFHD and over which the federal or state officials have jurisdiction.
4. Meetings held to meet in or nearby a facility owned by the agency, provided that the topic of the meeting is limited to items directly related to the facility.
5. Meetings held in an emergency situation pursuant to Government Code section 54956.5.

PROCEDURE:

Procedures in the Event of a Service Disruption

1. **Response to Service Disruption**
    a. If the Presiding Officer of the Board or Clerk becomes aware of a disruption to the agency's remote access services that prevents members of the public from attending or observing the meeting remotely:
        i. The Presiding Officer or Clerk shall immediately announce the disruption to the public.
        ii. The Presiding Officer may then call for a recess of the open session or convene the legislative body in closed session, consistent with the Brown Act.
        iii. Staff shall begin efforts to diagnose and restore the disrupted service.
        iv. The meeting shall remain in recess for at least one hour or until service is restored, whichever is sooner. The recess period may be extended if restoration efforts are ongoing.

2. **Efforts to Restore Service**

The agency shall make good faith efforts to restore remote access services, which may include:

a. Troubleshooting platform or teleconferencing software
b. Resetting or replacing audiovisual equipment
c. Attempting alternative connection methods
d. Contacting necessary support staff or service providers
e. Switching to back-up equipment or platforms, if available

The **TFHD Clerk** shall document the restoration efforts undertaken.

1. **Reconvening the Open Session**
    a. **Timing**
        i. The open session may be reconvened after at least one hour has elapsed from the time of disruption or as soon as service is restored, whichever occurs earlier.
    b. **If Service Is Restored**
        i. If the remote access service is restored before or at the time the meeting reconvenes, the meeting shall continue as normal.
    c. **If Service Is *Not* Restored**
        i. If service has not been restored after one hour, the **TFHD Board of Directors** may reconvene and:

1. Adjourn the meeting; or

2. ~~Continue the meeting in open session by adopting, by roll call vote, the following, or a substantially similar, finding:~~

~~"**Tahoe Forest Hospital District** has made good faith efforts to restore telephonic or internet service in accordance with its adopted policy, and the public interest in continuing the meeting outweighs the public interest in remote public access."~~

~~Upon adoption of the finding, the legislative body may continue the open session despite the fact that remote access services have not been restored.~~

~~1. **Recordkeeping**~~

~~a. The Clerk shall enter a brief statement into the meeting minutes, including the following:~~

~~i. The nature and time of the disruption~~

~~ii. The restoration efforts undertaken~~

~~iii. The time the meeting was reconvened (if applicable)~~

~~iv. Any finding adopted pursuant to Section 6.3~~

~~2. **Review and Updates**~~

~~a. This policy may be amended by the **TFHD Board of Directors** at a noticed public meeting in open session, not on the consent calendar.~~

A. **Procedures in the Event of a Service Disruption**

1. **Response to Service Disruption**

a. If the Presiding Officer of the Board or Clerk becomes aware of a service disruption to the agency's remote access services that prevents members of the public from attending or observing the meeting remotely:

i. The Presiding Officer or Clerk shall immediately announce the disruption to the public.

ii. The Presiding Officer may then call for a recess of the open session and may convene the Board in closed session, consistent with the Brown Act.

iii. During the recess, staff shall begin efforts to diagnose and restore the disrupted service.

iv. The meeting shall remain in recess for at least one hour or until service is restored, whichever is sooner. The recess period may be extended if restoration efforts are ongoing.

2. **Efforts to Restore Service**

a. The agency shall make good faith efforts to restore remote access services, which may include:

i. Troubleshooting platform or teleconferencing software

ii. Resetting or replacing audiovisual equipment

iii. Attempting alternative connection methods

iv. Contacting necessary support staff or service providers; and

v. Switching to back-up equipment or platforms, if available

B. The **TFHD Clerk** shall document the restoration efforts undertaken.

1. **Reconvening the Open Session**

a. **Timing**

i. The open session may be reconvened after at least one hour has elapsed from the time of service disruption or as soon as service is restored, whichever occurs earlier.

b. **If Service Is Restored**

i. If the remote access service is restored before or at the time the meeting reconvenes, the meeting shall continue as normal.

c. **If Service Is *Not* Restored**

i. If service has not been restored after one hour, the **TFHD Board of Directors** may reconvene and:

a. one - Adjourn the meeting; or

b. two - Extend the recess to allow staff more time to make a good faith efforts to restore remote access services; or

c. three - Continue the meeting in open session by adopting, by roll call vote, the following, or a substantially similar, finding:

i. "**Tahoe Forest Hospital District** has made good faith efforts to restore telephonic or internet service in accordance with its adopted policy, and the public interest in continuing the meeting outweighs the public interest in remote public access."

d. Upon adoption of the finding, the legislative body may continue the open session despite the fact that remote access services have not been restored.

C. **Record keeping**

1. The Clerk shall enter a brief statement into the meeting minutes, including the following:

a. The nature and time of the service disruption;

b. The restoration efforts undertaken;

c. The time the meeting was reconvened (if applicable); and

d. Any finding adopted regarding the public interest in continuing the meeting

D. **Review and Updates**

a. This policy may be amended by the **TFHD Board of Directors** at a noticed public meeting in open session, not on the consent calendar.

Attachments

Service Disruption Flowchart

Approval Signatures

Step Description	Approver	Date
	Anna Roth: President & CEO	Pending
	Sarah Jackson: Clerk of the Board	03/2026

TAHOE FOREST
HOSPITAL DISTRICT

AGENDA ITEM COVER SHEET

MEETING DATE: March 26, 2026	**ITEM:** Community Outreach for Underserved Communities and Hospital Board Meeting Engagement, ABD-2602
DEPARTMENT: Administration	**TYPE OF AGENDA ITEM:** ☒ Action ☐ Consent ☐ Discussion
RESPONSIBLE PARTY: Sarah Jackson, Clerk of the Board	**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:
Administrative and departmental operating policies must be reviewed *at least once every three years*, more often as necessary.

ABD-2602 is a new policy describing reasonable efforts the THFD Board of Directors may take to encourage participation in Board Meetings.

SUMMARY/OBJECTIVES:
Legislative bodies must make "reasonable efforts" to encourage groups that don't traditionally participate in meetings to participate through enhanced communications, accessibility enhancements, community partnerships, and direct engagement.

Legislative bodies have broad discretion over meeting outreach requirements and are shielded from legal action for failure to contact any specific group.

SUGGESTED DISCUSSION POINTS:
The purpose of this policy is to comply with SB707 Brown Act

SUGGESTED MOTION/ALTERNATIVES:
Move to recommend approval of ABD-2602 as presented.

Alternative Motion – recommend changes to ABD-2601 (if changes are recommended in discussion).

LIST OF ATTACHMENTS:
Community Outreach for Underserved Communities and Hospital Board Meeting Engagement, ABD-2602 (draft of new policy)

Status **Pending** PolicyStat ID **20097130**

Origination Date	N/A	Department	Board - ABD
Last Approved	N/A	Applicabilities	System
Last Revised	N/A		
Next Review	3 years after approval		

Community Outreach For Hospital Board Meeting Engagement, ABD-2602

RISK:

Insufficient engagement with under-served communities can reduce trust, limit the Board's understanding of community needs, impede improvements in health outcomes, and lead to inequitable or uninformed decision-making. Strengthening outreach helps mitigate these risks and supports transparent, community-centered governance.

POLICY:

A. The purpose of this policy is to strengthen the relationship between the Hospital District and the diverse communities it serves by increasing awareness of, access to, and participation in Hospital District board meetings. The Board is committed to ensuring that residents from traditionally under-served communities, including but not limited to racial and ethnic minorities, immigrants and refugees, people with disabilities, seniors, economically disadvantaged residents, and linguistically diverse populations, have equitable opportunities to engage in District governance and decision-making.

B. Community engagement for Hospital District Board meeting will be guided by the following principles:

1. Equity: Ensure that outreach efforts pro-actively address historical and structural barriers to participation.
2. Accessibility: Provide information, meeting access, and engagement opportunities in formats and languages that meet the needs of all community members.
3. Transparency: Promote open, timely, and culturally relevant communication about board activities, agendas, and opportunities for public input.

4. Collaboration: Partner with trusted community organizations, leaders, and networks to build long-term relationships.
5. Respect: Foster a welcoming environment where all community members feel heard, valued, and safe expressing their perspectives.

PROCEDURE:

A. Increase awareness of hospital board meetings and decision-making processes through outreach strategies.

B. Improve accessibility of meeting materials, formats, and participation options.

C. Build trust and two-way communication between the Board and under-served communities.

D. Outreach Strategies may include:

1. Enhanced Communication & Notification
    a. Publish meeting notices in English and Spanish, which is reflective the two largest percentages of languages spoken and written in the District.
    b. Distribute notices through culturally relevant channels, including community radio, social media groups, and newsletters.
    c. Provide plain-language summaries of agendas and topics.
    d. Create a sign-up system for email meeting alerts.
2. Accessibility Enhancements
    a. Offer hybrid meeting options (in-person and virtual).
    b. Provide live interpretation services and offer information on how to access translated materials.
    c. Ensure meeting locations and virtual platforms comply with accessibility standards.
3. Community Partnerships
    a. Collaborate with community-based organizations, faith communities, schools, and advocacy groups.
    b. Engage cultural brokers or community health workers to support trust-building.
    c. Attend community events outside formal meetings.
4. Direct Engagement
    a. Invite community representatives to present at board meetings.
    b. Seek feedback through multilingual and accessible surveys.

Definitions:

A. Under-served Communities: Groups that experience barriers to participation due to historical, social, economic, linguistic, or geographic disadvantages.

B. Outreach Activities: Any communication, engagement, partnership, or event intended to inform or involve community members in board proceedings.

C. Culture Broker: trusted intermediary that may act as a liaison, navigator, mediator, or advocate, rather than just a translator.

Approval Signatures

Step Description	Approver	Date
	Sarah Jackson: Clerk of the Board	Pending

TAHOE FOREST
HOSPITAL DISTRICT

AGENDA ITEM COVER SHEET

MEETING DATE: March 26, 2026	**ITEM:** 16.3. Guidelines for Business by the TFHD Board of Directors, ABD-12
DEPARTMENT: Administration	**TYPE OF AGENDA ITEM:** ☒ Action ☐ Consent ☐ Discussion
RESPONSIBLE PARTY: Sarah Jackson, Clerk of the Board	**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:
Administrative and departmental operating policies must be reviewed *at least once every three years*, more often as necessary.

ABD-12 explains the guidelines for the Board of Directors in conducting business for the THFD while maintaining compliance with the District Bylaws and the Brown Act.

SUMMARY/OBJECTIVES:
Recent updates to the Brown act requires additional explanations about Teleconferencing and public participation. Policy updated to reflect those changes.

The policy cannot be adopted on the consent calendar.

SUGGESTED DISCUSSION POINTS:
The purpose of this policy is to comply with SB707 Brown Act

SUGGESTED MOTION/ALTERNATIVES:
Move to recommend approval of ABD-12 as presented and send to March 26, 2026, TFHD Board of Directors for action.

Alternative Motion – recommend changes to ABD-12 (if changes are recommended in discussion).

LIST OF ATTACHMENTS:
Guidelines for Business by the TFHD Board of Directors, ABD-12 (redline)

Status **Pending** PolicyStat ID **19613377**

Origination Date	08/1990	Department	Board - ABD
Last Approved	N/A	Applicabilities	System
Last Revised	03/2026		
Next Review	3 years after approval		

Guidelines for Business by the Tahoe Forest Hospital District Board of Directors, ABD-12

RISK:

Failure to explain the guidelines for the Board of Directors in conducting business for the Tahoe Forest Hospital District and/or clarify the requirements of state law for public meetings while conducting business and meetings on behalf of the District could result in noncompliance with the Tahoe Forest Hospital District Bylaws and/or the Ralph M. Brown Act, hereinafter referred to as Brown Act.

POLICY:

In an effort to make known to any interested party the general guidelines for the conduct of business by the Board of Directors of the Tahoe Forest Hospital District, the following is a compendium of provisions from the District Bylaws and the Brown Act.

PROCEDURE:

A. **Officers of the Board of Directors**

1. The officers of the Board of Directors are: Chair, Vice Chair, Secretary and Treasurer.
2. The officers shall be chosen every year by the Board of Directors at a Board meeting in December and each officer shall hold office for a one-year term or until such officer's successor shall be elected and qualified or until such officer is otherwise disqualified to serve. The person holding the office of Chair of the Board of Directors may serve successive terms by unanimous vote taken at a regularly scheduled meeting. The office of Chair, Vice Chair, Secretary and Treasurer shall be filled by members of the Board of Directors.

B. **Meetings Of The Board of Directors**

1. Regular Meetings: Regular meetings of the Board of Directors shall be held the

fourth Thursday of each month at 4:00 PM at a location within the Hospital District boundaries, except for regular meetings in November and December which shall be held on the third Thursday of the month at 4:00 PM. The regular meeting shall begin in open session in accordance with the Brown Act and may adjourn to closed session in compliance with law. The notice for meetings of the Board of Directors and Board standing committees ("Committee(s)") shall be posted per the requirements of the Brown Act.

2. It is the duty, obligation, and responsibility of the Board Chair and Board Committee chairpersons to call for Board of Directors and Board Committee meetings and meeting locations. This authority is vested within the office of the Board Chair or the Board Committee chair and is expected to be used with the best interests of the District, Directors, staff and communities we serve.
3. Special Meetings: Special meetings of the Board of Directors may be held from time to time as specified in the District Bylaws and with the required 24 hours' notice as stated in the Brown Act.
    a. The Chair of the Board, or three directors, may call a special meeting in accordance with the notice and posting provisions of the Brown Act.
    b. Special meetings shall be called by delivering written notice to each Board Member and to the public in compliance with the Brown Act, including providing a description of the business to be transacted. Board Members may dispense with the written notice provision if a written waiver of notice has been filed with the Clerk before a meeting convenes.
    c. No business other than the purpose for which the special meeting was called shall be considered, discussed, or transacted at the meeting.
4. Emergency Meetings: Emergency meetings may be called in the event of an emergency situation, defined as a crippling disaster, work stoppage or other activity which severely impairs public health, safety or both, as determined by a majority of the Board, or in the event of a dire emergency, defined as a crippling disaster, mass destruction, terrorist act, or threatened terrorist activity so immediate and significant that requiring one hour notice before holding an emergency meeting may endanger the public health, safety, or both as determined by a majority of the Board.
    a. In the case of an emergency situation involving matters upon which prompt action is necessary due to the disruption or threatened disruption of public facilities, then a one (1) hour notice provision as prescribed by the Brown Act is required. In the event telephone communication services are not working, notice must be given as soon as possible after the meeting.
    b. No business other than the purpose for which the emergency meeting was called shall be considered, discussed, or transacted at the meeting.
5. Closed Session Meetings: Closed session meetings of the Board of Directors and Board Committees may be held as deemed necessary by members of the Board of Directors or the President & Chief Executive Officer (CEO) pursuant to the required notice and the restriction of subject matter as defined in the Brown Act and the Local

Health Care District Law.

a. Under no circumstances shall the Board of Directors order a closed session meeting for the purposes of discussing or deliberating, or to permit the discussion or deliberation in any closed meeting of any proposals regarding:

    i. The sale, conversion, contract for management, or leasing of any District health care facility or the assets thereof, to any for-profit or nonprofit entity, agency, association, organization, governmental body, person, partnership, corporation, or other district.

    ii. The conversion of any District health care facility to any other form of ownership by the District.

    iii. The dissolution of the District.

b. Documentation for closed session items may be provided on the Board portal at least 72 hours prior to the session for regular meetings and 24 hours before special closed session meetings. Once the session has been completed, all documentation will be removed from the portal. Hard copy documentation may be made available during the actual closed session but will be returned by all Board Members at the completion of the closed session.

c. As a best practice, closed session will be attended by General Counsel.

6. Teleconferencing (Traditional Teleconferencing, Reasonable Accommodation Teleconferencing, Just Cause Teleconferencing and Subsidiary Body Teleconferencing) : Any regular, special, or emergency meeting at which teleconferencing is utilized shall be conducted in compliance with the provisions of the Brown Act. These may include:

    a. All votes taken by teleconference must be taken by roll call.

    b. At least a quorum of the Board must participate from locations within the District boundaries.

    c. Two-way audio-visual platform must be active during the entirety of the meeting.

    d. Duty to disclose persons age 18+ present in the location and their relationship.

    e. Agenda and minutes must reflect which members participate remotely.

    f. Remote location must be at least 20 miles away from physical meeting location.

7. All meetings of the Board of Directors shall be chaired by members of the Board of Directors in the following order: Chair, Vice Chair, and Secretary.

C. **Activities/Meetings of Board Committees**

1. Board Committees will undertake the activities of the committee as outlined in the

Tahoe Forest Hospital District Bylaws. In addition, each Committee will annually establish Committee goals, and such goals will be presented to the Board of Directors for approval.

D. ~~**Meetings Open to the Public**~~
~~All meetings of the Board of Directors and Board Committees are open to the public with the exception of the closed session portion of such meetings and ad hoc committee meetings that are not subject to the Brown Act.~~**Meetings Open to the Public**
All meetings of the Board of Directors and Board Committees are open to the public with the exception of the closed session portion of such meetings and ad hoc committee meetings that are not subject to the Brown Act.
Members of the public must be able to attend and participate in meetings via:

1. Two-way telephone service: a dial-in service that does not require internet, OR
2. Two-way audiovisual platform: an online platform allowing both video conference and telephone service; must activate automatic captioning function
   Exception to D.1 and 2:
   a. If adequate telephone or internet service is not operational at the meeting location;
   b. If meeting is taking place outside the usual meeting location under specified circumstances, such as:
      i. Attending a judicial or administrative proceeding to which the District is a party.
      ii. Inspecting real or personal property provided that the topic of the meeting is limited to items directly related to the property.
      iii. Meeting with an elected or appointed official of the United States or the State of California, solely to discuss a legislative or regulatory issue affecting the District and over which the officials have jurisdiction.
      iv. Meeting in or nearby a facility owned by the District provided that the topic of the meeting is limited to items directly related to the facility.
   c. If the meeting is pursuant to an "emergency situation"

Disruptions to service of the two-way telephone service or two-way audiovisual platform during meetings shall be responded to in accordance with the procedures in ABD-2601.

E. **Notices of Meetings of the Board of Directors ~~and Board Committees~~ Supplied to the Public**
Notices of any regular or special meeting of the Board of Directors ~~and Board Committees~~ shall be e-mailed to any interested party who has ~~filed a written~~submitted a request for such notice. The request must be renewed annually in writing (email). Notices and agendas of any regular or special meeting are also posted on the District website or at a location freely accessible to the public.

F. **Board and Board Committee Agenda Packets for Members of the Public**

1. Board and Board Committee agendas and agenda materials are available for review

on the District website or at the Board or Board Committee meeting itself.

2. Any requests from the public for Board and Board Committee agenda packets shall be filled within a reasonable amount of time. Any member of the public requesting a Board or Board Committee agenda packet with all attachments shall be charged in accordance with the Inspection and Copying of Public Records, ABD-14 policy for such material. The charge is only intended to capture direct costs associated with complying with public requests for documents provided by the California Public Records Act. In no way does the District profit from this activity; but only seeks to remain fiscally prudent and provide equity of service while maintaining easy access. Additionally, any members of the public being able to demonstrate true indigence shall be exempted from the fee per page charges. An agenda packet with all attachments shall be made available for use by any interested party at all regular and special meetings of the Board of Directors and Board Committee meetings.

Public Input at Meetings of the Board of Directors and Board Committee Meetings
On each agenda of regular and special meetings of the Board of Directors and Board Committee meetings, there shall be a provision made for input from the audience. There shall be an equivalent opportunity for public comment via remote and in-person channels, including equal speaking time and procedural treatment, for meetings where the District is required to provide an opportunity for members of the public to attend via a two-way telephonic service or a two-way audiovisual platform.

G. ~~**Public Input at Meetings of the Board of Directors and Board Committee Meetings**~~
~~On each agenda of regular and special meetings of the~~The Board of Directors ~~and~~or Board Committee ~~meetings, there shall be a provision made for input from the audience. The Board of Directors or Board Committee~~ may impose a time limit for such public input. Pursuant to the Brown Act, items which have not previously been posted on the meeting agenda may not be discussed or acted upon at that meeting by the Board of Directors with the following exceptions:

1. If a majority of the Board of Directors determines that an emergency situation exists as defined under the "Emergency Meetings" section of this policy, or
2. If two-thirds of the members of the Board of Directors or Board Committee present at the meeting, or, if less than two-thirds of the members are present, a unanimous vote of those members present, agree an item requires immediate action and the need for action came to the District's attention after the agenda was posted, or
3. If the item was previously posted in connection with a meeting which occurred no more than 5 days prior to the date on which the proposed action will be taken.

H. **Preparation of the Agenda for Board or Board Committee Meetings**

1. Placing of Items on the Agenda:
    a. As provided for in the Brown Act pertaining to public input, the District will provide an opportunity for members of the public to address the Board on any matter within their subject matter jurisdiction at monthly, regularly scheduled meetings. It is the desire of the Board of Directors to adhere to legislative requirements and conduct the business of the District in a manner so as to address the needs and concerns of members of the

public.

b. Members of the public are directed to contact the Chair of the Board of Directors, a Director of the Board or the President & Chief Executive Officer at least two weeks prior to the meeting of the Board of Directors at which they wish to have an items placed on the agenda for discussion/action. Requests to Directors of the Board will be referred to the President & Chief Executive Officer for follow up. While the District values public input, the Board and District staff control meeting agendas and the District has no obligation to agendize a matter requested by a member of the public. If a matter is not agendized, the person seeking to discuss it may raise it in the public comment portion of a meeting.

c. No matters shall be placed on the agenda that are beyond the jurisdiction and authority of a Local Health Care District or that are not relevant to hospital district governance.

d. Last minute supporting documents by staff put Board Members at a disadvantage by diluting the opportunity to study the documents. All late submission of supporting documents must be justified in writing stating the reasons for the late submission. The Clerk will notify the Board of late submissions and their justification when appropriate. Bona fide emergency items involving public health and safety requiring Board action will be excluded.

2. The President & Chief Executive Officer and Board Chair, with input from members of the Board, shall prepare the agendas for the meetings of the Board of Directors. The President & Chief Executive Officer or his or her designee and the Board Committee chairperson shall prepare the agendas for the meetings of the Board Committees. Items to be placed on an agenda should be submitted to the President & Chief Executive Officer or the Clerk of the Board no later than 10 days prior to the Board meeting.
3. In addition to discussing with the Board Chair or President & Chief Executive Officer, a Board Member can ask that a topic be placed on next month's agenda for discussion during the appropriate time at a Board meeting. An item will be placed on next month's agenda if a majority of the Board concurs. No more than two items per Board Member will be considered at a Board meeting.
4. The format for agendas of meetings of the Board of Directors will be as follows unless the Board or President & Chief Executive Officer otherwise directs:
    a. Call to Order
    b. Roll Call
    c. Deletions/Corrections to the Posted Agenda
    d. Input – Audience
    e. Closed Session, if necessary
    f. Acknowledgments (if any)
    g. Medical Staff Executive Committee

h. Consent Calendar

i. Items for Board Action

j. Items for Board Discussion

k. Discussion of Consent Calendar Items Pulled, if necessary

l. Board Members Reports/Closing Remarks

5. The Board of Directors wishes to facilitate input from members of the Medical Staff. When possible, items of concern to the members of the Medical Staff will be placed as a timed item in the agenda as appropriate within the format as detailed above to minimize the demands on the time of the Medical Staff members.

6. The Board Chair and the President & Chief Executive Officer will create a "Consent Calendar" for those items on the agenda which are reasonably expected to be routine and non-controversial. The Board of Directors shall consider all of the items on the agenda marked consent calendar at one time by vote after a motion has been duly made and seconded. If any member of the Board of Directors or District staff requests that a consent item be removed from the list of consent items prior to the vote on the consent calendar, such item shall be taken up for separate consideration and disposition. Members of the public may request a Board Member do so on their behalf, or may provide public comment on a particular item before the Board votes on the consent calendar.

    a. Board Members are encouraged to notify the Board Chair and President & Chief Executive Officer prior to a meeting if there is intent to pull an item and/or provide questions and concerns. This will enable proper preparation to address questions and concerns.

    b. Department Heads, or their designated representative, will be present during the consent calendar to answer any questions. If the Department Head is unable to attend, the President & Chief Executive Officer will respond to questions and/or the item may be postponed until later in the meeting or a following meeting if necessary.

7. The Chair of the Board of Directors will approve the agenda before its distribution.

I. **Notification by Board Member of Anticipated Absences**
In the event a Board Member will be out of the area or unable to participate in a meeting, the Board Member is to provide written or electronic notification to the Clerk of the Board with information including the dates of absence and best method of contact.

J. **Minutes of Meetings of the Board of Directors and Board Committees**
Minutes of meetings of the Board of Directors and Board Committees shall be taken by the Clerk of the Board. The minutes shall be transcribed by the Clerk of the Board and reviewed by the President & Chief Executive Officer prior to submittal to the Board of Directors or Board Committees for review and approval at their next regularly scheduled meeting.

K. **Discussion/Debate**

1. As is practical, staff oral summaries shall precede motions and public comment on an agendized item.

2. Invited outside presenters, such as our auditors, accountants, and legal counsel shall offer their comments and documentation prior to a motion being introduced by one of the Board Members and public comment on an agendized item.
3. *Brief* questions to fill in knowledge gaps or to provide clarification should be posed prior to motion language being introduced and public input/comments on an agendized item. This is not an opportunity for Board Members to state their views on the substance of a matter.
4. Any Board Committee input or recommendations should be presented prior to a motion. Again, *brief* questioning for clarification may be engaged in prior to motions; this is not an opportunity for Board Members to state their views on the substance of a matter.
5. Public input/comments regarding items not on the agenda will be sought at the beginning of Board/Board Committee meetings during the time allotted for public input. Public input/comments regarding agendized items will be sought during the consideration of these items, before action is taken, at Board/Board Committee meetings. It is noted that presentations from outside organizations may be referred to a Board Committee by the Board Chair for the formulation of a recommendation to the Board of Directors.
6. Requests by Board Members during a meeting for the opportunity to speak, for public input, or for additional staff input, should be made through the Board Chair.

L. **Voting/Motions**

1. Any member of the Board of Directors may introduce or second a motion, including the Board Chair or other currently presiding officer. All members, including the Board Chair, are encouraged to vote on all motions presented while in attendance unless required to abstain by a conflict of interest or other law. If a Director's vote is not discernible, the vote shall be recorded as in favor of the motion.
2. Amendment of a motion may only be amended by the motion maker with the concurrence of the second.
3. No more than one motion can be considered at a time.
4. Recording of the vote shall be first done by voice vote, with exception going to resolutions that require a roll call vote as a matter of law. Any member may request a roll call vote on any motion; such requests will not require a second and shall be performed at once.
5. Three votes of the Board, unless a greater number is required by law, are required to constitute a Board action. A tie vote on a motion affecting the merits of any matter shall be deemed to be a denial of the matter.
6. Motion of Reconsideration: When additional information has surfaced at a meeting after a motion has duly passed or failed, a motion for reconsideration may be accepted only if advanced or seconded by a Board Member that voted in the minority on the original motion. The Board Chair may reschedule an item if the participating public was present when originally considered and departed before reconsideration. Questions from the Board will occur prior to public comment. Items will not be debated by the Board until after public comment has been closed.

7. "Secret ballots" or any other means of casting anonymous or confidential votes are strictly prohibited per law. All votes shall be recorded and be available for public review.
8. Unless otherwise noted, all Board related business, whether in committee or Board session (open or closed) shall be conducted in compliance with this policy. The Board formally adopts this method of conducting business to ensure that all Board affairs are conducted in an equitable, orderly and timely fashion. Parliamentary procedures are seen as a valuable tool for proper conduct in meetings, and should provide a degree of standardization in regards to other governmental interests, facilitating the public's understanding (and other governmental bodies' understanding) our actions.

M. **Urgent Decisions**
In the event that an urgent or emergent decision or action is required by the Board prior to a regularly scheduled meeting, the Chair of the Board, or a majority of the Board Members, may call a special or emergency Board meeting to take action.

N. **Contingent Approval**

1. In the event the Board approves an item at a Board meeting in which all of the terms, conditions, restrictions, commitments, etc. are clearly defined, but which such provisions have not been formalized in contracts or other appropriate documentation, the Board may give preliminary approval to the President & Chief Executive Officer to execute the contract or other appropriate documentation, contingent upon the following:
    a. the terms are not substantively altered from those previously approved,
    b. all involved parties to the transaction or agreement are notified in writing of the contingent approval of the terms pending ratification by the Board, and
    c. the final terms and documentation are approved or rejected by the Board at a subsequent Board meeting.
2. If the terms of the supporting documentation are substantively different than those previously approved at the public meeting, then approval must be obtained at a subsequent Board meeting.

O. **Complaints Addressed to the Board**
Written comments or complaints addressed to any or all members of the Board that are received by Board Members or Health System staff member must be forwarded immediately to the Clerk of the Board. The Clerk of the Board will deliver copies of complaints to the President & CEO and Health System's Patient Experience Specialist.

P. **Board Member Request for Information**

1. Individual Board Members may request data from the District by completing a Board of Directors Information Request Form indicating the specific information requested.
    a. The President & CEO will review the request to determine material availability, sensitivity, necessary resources, and anticipated cost (if any) of production.

b. Should the President & CEO determine that materials are not readily available, sensitive in nature or costly to produce, the President & CEO may defer to a decision of the Board of Directors to fulfill the request.

c. All approved requests by the President & CEO and/or the Board of Directors will be produced and distributed to each member of the Board of Directors.

Related Policies/Forms:

Board of Directors Information Request Form

References:

Ralph M. Brown Act (CA Govt Code §54950)

All Revision Dates

03/2026, 12/2022, 07/2019, 08/2018, 03/2016, 12/2015, 06/2014, 01/2014, 01/2012, 03/2008

Attachments

Information Request Form.pdf

Approval Signatures

Step Description	Approver	Date
	Anna Roth: President & CEO	Pending
	Sarah Jackson: Clerk of the Board	03/2026