TAHOE FOREST HOSPITAL DISTRICT

2022-02-10 Board Quality Committee Meeting

Thursday, February 10, 2022 at 12:00 p.m.

Pursuant to Assembly Bill 361, the Board Quality Committee meeting for February 10, 2022 will be conducted telephonically through Zoom.

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

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

If you would like to speak on an agenda item, you can access the meeting remotely: Please use this web link: https://tfhd.zoom.us/j/81319375544

If you prefer to use your phone, you may call in using the numbers: (346) 248 7799 or (301) 715 8592, Meeting ID: 813 1937 5544

TAHOE FOREST HOSPITAL DISTRICT

Meeting Book - 2022-02-10 Board Quality Committee Meeting

TAHOE FOREST HOSPITAL DISTRICT

QUALITY COMMITTEE
AGENDA

Thursday, February 10, 2022 at 12:00 p.m.

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

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

1. CALL TO ORDER

2. ROLL CALL
Michael McGarry, Chair; Alyce Wong, RN, Board Member

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

4. INPUT – AUDIENCE
This is an opportunity for members of the public to address the Committee 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 Committee cannot take action on any item not on the agenda. The Committee 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.

5. APPROVAL OF MINUTES OF: 11/29/2021 ..... ATTACHMENT

6. ITEMS FOR COMMITTEE DISCUSSION AND/OR RECOMMENDATION

6.1. Safety First

6.2. Patient & Family Centered Care

6.2.1. Patient & Family Advisory Council (PFAC) Update ..... ATTACHMENT
An update will be provided related to the activities of the Patient and Family Advisory Council (PFAC).

6.3. Patient Safety

6.3.1. BETA HEART Program Progress Report..... ATTACHMENT
Quality Committee will receive a progress report regarding the BETA Healthcare Group Culture of Safety program.

6.4. TFHD Care Compare Quality Metrics ..... ATTACHMENT
Quality Committee will receive an overview of the Care Compare Quality metrics and plans for improvement.

6.4.1. Surgical Site Infection Report..... ATTACHMENT
Quality Committee will receive a summary report of the publicly reported SSI data and the District's prevention practices.

6.5. Governance of Quality Assessment (GQA) Tool ..... ATTACHMENT
Quality Committee will receive an update on the following core process: *Board reviews metrics related to access to care at all points in the system (e.g., hospital, clinics, behavioral health, nursing home, home care, dental) and ensures that access is equitable and timely for all patients. Framework for Effective Board Governance of Health System Quality* (2018). Daley Ullem E, Gandhi TK, Mate K, Whittington J, Renton M, Huebner J. Boston, Massachusetts: Institute for Healthcare Improvement.

6.6. Quality Assurance/Process Improvement Plan (QA/PI)..... ATTACHMENT
Quality Committee will review the proposed QA/PI 2022 priorities.

6.7. Board Quality Education

6.7.1. *Final Recommendations: Future of Rural Health Care Task Force (2021).* American Hospital Association. Retrieve on 12/8/2021 from https://www.aha.org/2021-05-17-final-recommendations-future-rural-health-care-task-force-may-2021**.....** ATTACHMENT

6.8. Board Quality Committee Charter ..... ATTACHMENT
Quality Committee will review its committee charter.

7. REVIEW FOLLOW UP ITEMS / BOARD MEETING RECOMMENDATIONS

8. NEXT MEETING DATE
The next committee date and time will be confirmed.

9. ADJOURN

*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 Executive Assistant at 582-3481 at least 24 hours in advance of the meeting.

TAHOE FOREST HOSPITAL DISTRICT

BOARD QUALITY COMMITTEE
DRAFT MINUTES

Monday, November 29, 2021 at 12:00 p.m.

Pursuant to Assembly Bill 361, the Board Quality Committee meeting for November 29, 2021 will be conducted telephonically through Zoom. Please be advised that pursuant to legislation and to ensure the health and safety of the public by limiting human contact that could spread the COVID-19 virus, the Eskridge Conference Room will not be open for the meeting. Committee Members will be participating telephonically and will not be physically present in the Eskridge Conference Room.

1. CALL TO ORDER

Meeting was called to order at 12:00 p.m.

2. ROLL CALL

Board: Michael McGarry, Chair; Alyce Wong, RN, Board Member

Staff in attendance: Harry Weis, President & CEO; Crystal Betts, Chief Financial Officer; Karen Baffone, Chief Nursing Officer; Jan Iida, Chief Nursing Officer; Dr. Shawni Coll, Chief Medical Officer; Scott Baker, VP Provider Services; Janet Van Gelder, Director of Quality & Regulations; Brian Parrish, Manager – MSC Clinics; Theresa Crowe, Risk Manager; Lorna Tirman, Patient Experience Specialist; Ken Munsterman, Director of Specialty Services; Dorothy Piper, Director of Medical Staff Services

Other: Kevin Ward, Patient Family Advisory Committee member

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

No changes were made to the agenda.

4. INPUT – AUDIENCE

No public comment was received.

5. APPROVAL OF MINUTES OF: 08/17/2021

Director Wong moved to approve the Board Quality Committee minutes of August 17, 2021, seconded by Director McGarry.

6. ITEMS FOR COMMITTEE DISCUSSION AND/OR RECOMMENDATION

6.1. Safety First

Safety First topics reviewed included myChart communications between patients and physicians and High Reliability.

Dr. Peter Taylor, Medical Director of Quality, joined the meeting at 12:05 p.m.

6.2. Patient & Family Centered Care

6.2.1. Patient & Family Advisory Council (PFAC) Update

Lorna Tirman, Patient Experience Specialist, provided an update related to the activities of the Patient and Family Advisory Council (PFAC).

6.3. Patient Safety

6.3.1. BETA HEART Program Progress Report

Patient Experience Specialist reviewed the BETA Healthcare Group Culture of Safety Program Progress Report.

Administrative Council just signed the agreement to participate in BETA HEART program next year. The criteria will not change for 2022.

6.4. Governance of Quality Assessment (GQA) Tool

Quality Committee received an update on the following core process: *Board evaluates approach to integration and continuity of care for behavioral health patients.*

Framework for Effective Board Governance of Health System Quality (2018). Daley Ullem E, Gandhi TK, Mate K, Whittington J, Renton M, Huebner J. Boston, Massachusetts: Institute for Healthcare Improvement.

Brian Parrish, Manager of MultiSpecialty Clinics, reviewed current staffing and key accomplishments of the Behavioral Health department. Mr. Parrish also reviewed depression screening data and the Medication Assisted Treatment program.

6.5. TFHD Care Compare Quality Metrics

Janet Van Gelder, Director of Quality, provided an overview of the Care Compare Quality metrics and plans for improvement. There are a total 40 quality metrics. TFHD submitted 18 out of 40 metrics.

CMS changed how it calculated the rating. In May, Tahoe Forest Hospital's star rating went from four to two. The Health System identified a number of opportunities for improvement. The data used to calculate the star rating is from 2017-2019. Director of Quality reviewed eight low scoring measures. Discussion was held.

6.6. Board Quality Education

6.6.1. Perlo J, Balik B, Swensen S, Kabcenell A, Landsman J, Feeley D. *IHI Framework for Improving Joy in Work.* IHI White Paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2017.

CMO shared burnout reduction strategies for the Medical Staff. Discussion was held.

7. REVIEW FOLLOW UP ITEMS / BOARD MEETING RECOMMENDATIONS

No discussion was held.

8. NEXT MEETING DATE

The next committee date and time will be confirmed.

9. ADJOURN

Meeting adjourned at 1:30 p.m.

Patient and Family Advisory Council (PFAC) Summary Report

February 2021 to February 2022

Submitted by: Lorna Tirman, RN, MHA, PhD, CPXP

Patient Experience Specialist

- Some members have shown an interest in serving in other areas of the hospital in addition to the monthly PFAC meetings. Kevin Ward volunteers in the Quality Department tracking our service recovery toolkits. Kevin Ward also serves on our Board Quality Committee, which meets quarterly. Pati Johnson serves as a volunteer on our Cancer Committee. Alan Kern participates on our Medical Staff Quality Committee.

- Meetings focus on improving processes and behaviors to continue to provide the Perfect Care Experience to our community and visitors.

- Plan for 2022 is to continue to review patient feedback and comments from patient experience surveys, help improve quality, safety, and patient experiences. Goals to help educate community on mental health services expand support for community both during and post COVID. Continue to educate community on COVID vaccination, safety, as well as, access to health care services, and making sure TFHD meeting the needs of our community and its growth.

- We agreed to continue to invite Department leaders to PFAC meetings to illicit input where needed and to improve processes or strategies in that specific area.

- At some of our meetings, an example of a patient complaint will be shared, to illicit input on how to best perform service recovery, and improve the process so the complaint will not happen again to another patient.

- February: Eileen Knudsen, Natasha Lukasiewich, and Karen Grow gave an update on current mental health resources at TFHD as well as in the community. PFAC giving updates to create a one-page flyer as soon as we have all the resources and information we need to promote these important services.

- March: Reviewed discharge folders for Inpatient and OB, that are being paid for by a State Grant, to improve communication to our patients upon discharge from our inpatient units.

- April: Svieta Schopp gave an update on Covid, Covid variants, vaccines and answered questions. Jim Sturtevant gave a summary of his presentation “Humor in Medicine”.

- May: A presentation by Wendy Buchanan and Maria Martin about all the community wellness programs and goals and initiatives of our population health program.

- June: Updates on ongoing vaccinations and boosters and Covid in our area, request for updates on increased needs of the community for specialists, urgent care, and access to primary care providers.

- September: We had a discussion on what topics PFAC would like to see in the next year. They all agreed to have an update on culture of safety survey, provider burnout initiatives, and support from the health system. New volunteer coordinator to introduce herself and update group on volunteers, needs and other information. Mental health updates to be scheduled. Plan to bring patient experience feedback and obtain input on how to improve our lowest scoring areas. Access center and financial customer service leaders to speak and answer questions about access and help with payment and bills, insurance etc. Updates on specialists, primary care providers, and urgent care. We discussed the need for increased security and helping our patients and staff feel safe throughout the healthcare system.

- October: Sam Smith presented on the provider well-being committee and what the healthcare system is doing to help with provider burnout. Becca Scott, the new volunteer coordinator, introduced herself and provided a summary of volunteer activities. She received feedback from the group on how to recruit more volunteers and how to measure engagement and volunteer satisfaction via an annual survey. PFAC offered to help finalize a survey if Becca drafts one. Maria Martin from the wellness neighborhood asked for feedback on a community postcard and flyer to educate community about wellness programs using a QR code. The entire group loved the idea and scanned the QR during the meeting to access programs, which was a huge success.

- November: Crystal Jefferson gave an update on our Patient Financial Customer Service team and reviewed most common billing complaints. PFAC recommended TFHD find ways to inform all of the community about this great and helpful program. Harry Weis gave updates on hospital leadership changes, and strategic plans to increase access, space, parking etc in the future.

- We did not meet in December 2021 or January 2022.

- The Tahoe Forest Hospital Patient and Family Advisory Council meets every month, 9 months in the year. We do not meet July, August, or December.

- Next PFAC Meeting is February 15, 2022.

Current members:

Name of PFAC Volunteer	**Start Date**
1. Doug Wright	2/4/2015
2. Anne Liston	3/9/2016
3. Mary K. Jones	5/17/2017
4. Dr. Jay Shaw	8/11/2017
5. Pati Johnson	3/22/2018
6. Helen Shadowens	5/24/2018
7. Kevin Ward	9/20/2018
8. Sandy Horn	9/5/2019
9. Violet Nakayama	10/31/2019
10. Alan Kern	2/20/2020
11. Kathee Hansen	4/1/2021

Beta HEART Progress Report for Year 2022

(February 2022)

Beginning in 2020, Beta Healthcare Group changed their annual Incentive process to be "Annual", meaning that each year the five (5) domains have to be re-validated each year to be eligible for the incentive credit. General updates for 2022:

- Beta Heart Validation Survey completed on 5/11/21 with validation in all 5 domains with a total cost savings of $108, 652.00
- Beta Heart Validation Survey scheduled for May 2022

Domain	History of Incentive Credits (2% annually)	Readiness for next Validation	Goal	Comments
Culture of Safety: A process for measuring safety culture and staff engagement (Lead: Lorna Tirman, Beta Heart Lead)	Validated 2019: $13,101 2020: $19,829 2021:$21,730.40	100%	Goal= Greater than 85% Response rate	Culture of Safety survey scheduled February 28-March 21, 2022. Reports will be distributed in April 2022 and debrief sessions will take place May through July 2022.
Rapid Event Response and analysis: A formalized process for early identification and rapid response to adverse events that includes an investigatory process that integrates human factors and systems analysis while applying Just Culture principles (Lead: Theresa Crowe, Risk Manager)	Validated 2020: $19,829 2021:$21,730.40	100%	Reinforce education related to timely event reporting and implementation of corrective action items.	TFHD incorporates the transparent and timely reporting of safety events to ensure rapid change in providing safer patient care. All investigations utilize "just culture" and high reliability principles and encourage accountability. Ten leaders scheduled to attend Beta Heart Workshop in Los Angeles, February 24-25, 2022.
Communication and transparency: A commitment to honest and transparent communication with patients and family members after an adverse event (Lead: Theresa Crowe, Risk Manager)	Validated 2020: $19,829 2021: $21,730.40	100%	Reinforce Beta HEART principles through targeted education at meetings, emails, Pacesetter, weekly Safety First, etc.	Disclosure checklist updated and refined as we update process and leaders trained to respond to events. This domain was reviewed at Beta Workshop II on April 22-23, 2021 and 9 employees/providers participated in the virtual learning. An Intermediate Communication skill development session was May 19-20, 2021 and 20 employees attended virtually. Plan to send at least 12 leaders to April 2022 workshop.
Care for the Caregiver: An organizational program that ensures support for caregivers involved in an adverse event (Lead: Stephen Hicks, Peer Support Lead)	Validated 2020: $19,829 2021: $21,730.40	100%	Proactive support to peers, not just after adverse events	Ongoing training and monthly peer support meetings. Virtual peer support training provided by Beta staff in June 2021, with 18 peer supporters in attendance. Ongoing peer support as needed for all staff and providers, sunshine cart rounds weekly, courageous conversations monthly, and posted on intranet.
Early Resolution: A process for early resolution when harm is deemed the result of inappropriate care or medical error (Lead: Theresa Crowe, Risk Manager)	Validated 2020: $19,829 2021: $21,730.40	100%	"Pacesetter Article" and "Safety Firsts" to enforce the principles of the 5 Domains	Early Resolution is the final domain and is only achieved by successfully completing all 4 prior domains. TFHD utilizes the BETA Heart Dashboard to monitor the effectiveness of meeting these goals. Beta Workshop III on October 1, 2021 and 12 employees attended virtually. Plan to send at least 12 leaders to October 2022 training.

Define	Measure	Analyze	Improve	Control	Process Improvement Implemented
Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and Total Knee Arthroplasty (TKA)	COMP-HIP-KNEE is the metric identifier with CMS.	Reviewed HSAG claims data to identify complications. Developed complication report for concurrent review & follow up. Multidisciplinary team meets weekly and transitioned to monthly in October 2021 to review data and process improvement plans. Quality Analyst to develop complication report for concurrent and retrospective review. Multidisciplinary team working on pulmonary emboli order set, including adding PESI score.	1. Coders will send HIM Director all retrospective complications for Quality or Infection Preventionist, and physician review prior to submitting the claim for payment. Concurrent review of identified complications. Refer to physician if documentation revisions are needed. 2. Develop and educate staff to the pulmonary emboli order set, including PESI score flowsheet in Mercy Epic. 3. Share complication report with Orthopedic RN Navigator to assist with tracking & trending. 4. Met with Orthopedic Medical Director & Surgery Department Chair in December to review SSI SIR rates & discuss areas for improvement. Report reviewed at Surgery Department meeting on 1/10/22. 5. All TJRs are referred to Preoperative Clinic to optimize the patient for surgery. Ortho Navigators address patient co-morbidities and appropriateness for surgery, especially revision surgeries. 6. Orthopedic RN Navigators to refer patients to HHA PT, based on establishted criteria, for preoperative home assessment. Determine if we can conduct preoperative visits to determine HHA/PT needs postoperatively.	Concurrent review of complications to identify root causes and ensure identified plans for improvement are effective.	Educated physicians & RN staff regarding utilization of Ancef despite history of rash or other allergic reaction. Also administering additional antibiotic dose if surgery greater than 2 hours long. Continue to explore implementation of preoperative home assessment visits by PT.
Hospital-Level 30-Day All-Cause Risk-Standardized Readmission Rate (RSRR) Following Elective Total Hip Arthroplasty (THA)/Total Knee Arthroplasty (TKA)	READM-30-Hip-Knee is the metric identifier with CMS.	Reviewed HSAG claims data to identify root causes. Developed daily readmission report for concurrent review & follow up. Developed readmission report 1/1/2019 thru present. Plan to review cases from 7/1/2020 thru present to identify root causes. Additional focus & review of home health patient readmissions. Multidisciplinary team meets weekly and transitioned to monthly in October 2021 to review data.	1. HHA revised the discharge criteria to ensure appropriate patient LOS based on diagnosis and care coordination needs. 2. NCM to review & forward HHA leadership concurrent readmission audit report for their review & follow up. HHA leadership reviews all HHA readmissions to identify areas for improvement. 3. NCM auditing all discharge codes for accuracy. Coders will validate discharge codes. 4. NCM to review & forward surgical readmissions to Quality Director for Medical Staff review. 5. NCM continue to monitor appropriate admit status using Interqual for all patients to ensure accuracy. Consider admitting to IP if patient requires SNF placement & 3 day qualifying stay. 6. NCM to review & forward Orthopedic leadership & Ortho Navigator concurrent readmission audit report for their review & follow up. 7. TCM patient follow up visit within 7 days as part of HHA protocol. 8. Ensure PCP follow up appointment is scheduled prior to patient discharge. Explore postoperative clinic. 9. Conduct Senior Services resources gap analysis to identify community needs and identify plans for improvement. 10. Preoperative Clinic instituted in July 2021 with evidence based screening criteria to optimize patient selection and manage risk. 11. Explore ECC/LTC bed hold for swing status type patient access to bed post acute care stay that need additional rehabilitation services. 12. Follow chain of command if Orthopedic Care Coordinators have concerns with a planned surgery and the physician does not agree with their assessment to delay the surgery.13. Meeting in January 2022 with Hospitalists, ED Chair, and NCM to discuss admissions and opportunities for improvement. 14. HHA & Rehab Services leadership meeting with Orthopedic Medical Director on 11/29/21 to discuss referrals. 15. Orthopedic RN Navigators to refer patients to HHA PT, based on establishted criteria, for preoperative home assessment.	Concurrent review of readmissions to identify root causes and ensure identified plans for improvement are effective.	Met with Orthopedic Medical Director to discuss opportunities for improvement.
Emergency Department (ED) Visits for Patients Receiving Outpatient Chemotherapy	OP-35 ED is the metric identifier with CMS.	Review readmission metric and data with ED & Cancer Center Medical Director & Nursing leadership. Quality Analyst to develop report for concurrent and retrospective chart audit to identify root causes.	1. Meeting with Medical Oncologists & CC leadership in December to discuss palliative care; expanding RN triage; & MD assessment prior to infusion center discharge. 2. Continue to conduct chart audits of all readmissions to identify trends and plans for improvement. 3. Review findings at quarterly Cancer Committee meeting.	Concurrent review of readmissions to identify root causes and ensure identified plans for improvement are effective.	Educated Oncologists & ED providers. Utilize PCC after hours & weekends for IV hydration if needed.
Clostridium Difficile (C.difficile)	HAI-6 is the metric identifier with CMS.	Daily review of Clostridium Difficile (C.difficile) testing and reporting at Safety Huddle.	1. Infection Preventionist contacted by staff before ordering test to ensure appropriateness. Laboratory staff rejects specimen if not appropriate. 2. C-difficile education & educational cards provided for Medical & Nursing staff. 3. Meeting with Hospitalists in January 2022 to review ordering criteria and order approvals by CMO or ID MD. 4. Create a hard stop in EHR. 5. CME by ID MD in 2022 on when to order testing. 6. Pharmacist participate in daily rounds and assist with antibiotic recommendations and by reviewing culture results and making changes as needed.	Daily review of Clostridium Difficile (C.difficile) testing to ensure identified plans for improvement are effective.	Dr. Hovenic educated ED & Hospitalists regarding testing. RN staff education regarding testing. Redistribute HASG cards to all staff.

HWR Hospital-Wide All-Cause Unplanned Readmission	READM-30-HOSP-WIDE is the metric identifier with CMS.	Reviewed HSAG claims data to identify root causes. Developed daily readmission report for concurrent review & follow up. Developed readmission report 1/1/2019 thru present. Plan to review cases from 7/1/2020 thru present to identify root causes. Additional focus & review of home health patient readmissions. Multidisciplinary team meets weekly to review data.	1. HHA revised the discharge criteria to ensure appropriate patient LOS based on diagnosis and care coordination needs. 2. NCM to review & forward HHA leadership concurrent readmission audit report for their review & follow up. HHA leadership reviews all HHA readmissions to identify areas for improvement. 3. NCM auditing all discharge codes for accuracy. Coders will validate discharge codes. 4. NCM to review & forward surgical readmissions to Quality Director for Medical Staff review. 5. NCM continue to monitor appropriate admit status using Interqual for all patients to ensure accuracy. Consider admitting to IP if patient requires SNF placement & 3 day qualifying stay. 6. NCM to review & forward Orthopedic leadership & Ortho Navigator concurrent readmission audit report for their review & follow up. 7. TCM patient follow up visit within 7 days as part of HHA protocol. 8. Ensure PCP follow up appointment is scheduled prior to patient discharge. Explore postoperative clinic. 9. Conduct Senior Services resources gap analysis to identify community needs and identify plans for improvement. 10. Preoperative Clinic instituted in July 2021 with evidence based screening criteria to optimize patient selection and manage risk. 11. Explore ECC/LTC bed hold for swing status type patient access to bed post acute care stay that need additional rehabilitation services. 12. Follow chain of command if Orthopedic Care Coordinators have concerns with a planned surgery and the physician does not agree with their assessment to delay the surgery.13. Meeting in January 2022 with Hospitalists, ED Chair, and NCM to discuss admissions and opportunities for improvement. 14. HHA & Rehab Services leadership meeting with Orthopedic Medical Director on 11/29/21 to discuss referrals. 15. Orthopedic RN Navigators to refer patients to HHA PT, based on establishted criteria, for preoperative home assessment.	Concurrent review of readmissions to identify root causes and ensure identified plans for improvement are effective.	Met with Hospitalists on 1/5/22 to discuss opportunities for improvement
Admit Decision Time to ED Departure Time for Admitted Patients	ED-2b is the metric identifier with CMS.	Review readmission metric and data with ED & Hospitalist Medical Director & Nursing leadership. Clinical Integration Analyst sending monthly reports to CNO, ED Medical & RN Director/Manager.	1. ED MD will note admit time after they complete patient work up and notify the Hospitalist of the admission. 2. Nursing staff will limit the admission holds to 30 minutes or less during change of shift.	Concurrent review of ED to inpatient admission data to identify root causes and ensure identified plans for improvement are effective.	Educated ED providers to document admit time once Hospitalist contacted & work up completed.
Abdomen CT Use of Contrast Material	OP-10 is the metric identifier with CMS.	Review abdomen CT use of contrast material metric and data with Diagnostic Imaging Medical Director & leadership. DI Medical Director to review ACR appropriate criteria with Medicine Department & ED Department related to abdominal CT orders.	1. Medicine & ED providers to follow ACR appropriate criteria when ordering abomen CT scans. 2. Technologist will contact the ordering physician if diagnostic test ordered is incorrect or not following ACR guidelines and ask for Radiologist input if still not clear. 3. Meeting with Primary Care Committee in December to discuss ordering practices and best practice recommendations. 4. DI staff to screen Outpatient testing orders from non TFHD Medical Staff providers to ensure following ACR critera. 5. Review at ED and Medicine Department meeting in 2022.	Concurrent review of abdomen CT use of contrast material to identify root causes and ensure identified plans for improvement are effective.	Educated ED and Medicine Department providers
Admissions for Patients Receiving Outpatient Chemotherapy	OP-35 ADM is the metric identifier with CMS.	Review readmission metric and data with ED & Cancer Center Medical Director & Nursing leadership. Quality Analyst to develop report for concurrent and retrospective chart audit to identify root causes.	1. Meeting with Medical Oncologists & CC leadership in December to discuss palliative care; expanding RN triage; & MD assessment prior to infusion center discharge. 2. Continue to conduct chart audits of all readmissions to identify trends and plans for improvement. 3. Review findings at quarterly Cancer Committee meeting.	Concurrent review of readmissions to identify root causes and ensure identified plans for improvement are effective.	Educated Oncologists, ED and Hospitalist providers. Utilize PCC after hours & weekends for IV hydration if needed.

Surgical Site Infections Update February 10, 2022

Svetlana Schopp, MSN, RN, CIC
Infection Preventionist
Department of Quality & Risk

Reporting Using Standardized Infection Ratio

- Standardized Infection Ratio (SIR) is used in public reporting of the SSI data
- September 2021: Performance Improvement Committee (PIC) recommended using SIR for internal SSIs reporting to align with public reporting
- Terminology:
  - **NHSN**: National Healthcare Safety Network
    - National healthcare-associated infection (HAI) tracking system
    - NHSN **provides** facilities, states, regions, and the nation with **data needed to identify problem areas, measure progress of prevention efforts**, and ultimately eliminate healthcare-associated infections
  - **SIR**: Standardized Infection Ratio
    - The SIR adjusts for various facility and/or patient-level factors that contribute to HAI risk within each facility
  - **SIR** calculation = Observed (O)/Predicted (P)
    - SIR greater than 1.0 indicates that more HAIs were observed than predicted
    - SIR less than 1.0 indicates that fewer HAIs were observed than predicted

CDC, 2021

Publicly Reported Data

2019

Hospital/SIR ▸ Type of Procedure ▾	Tahoe Forest Hospital (CAH)	Mammoth Hospital (CAH)	Barton Memorial Hospital (Community <125beds)	Sierra Nevada Memorial Hospital (Community <125beds)	Marshal Medical Center (Community <125beds)
Appendix	* (0/34) 0.1	* (0/23) 0.1	* (0/38) 0.1	5.00 (1/78) 0.2	* (0/49) 0.1
Cesarean Section	0.00 (0/98) 0.2	* (0/20) 0.0	* (0/53) 0.1	* (0/99) 0.2	* (0/110) 0.1
Colon	0.00 (0/15) 0.2	* (0/3) 0.0	1.25 (1/33) 0.8	0.86 (1/74) 1.2	1.68 (2/57) 1.2
Ex Lap	* (0/19) 0.1	* (0/3) 0.0	0.00 (0/47) 0.3	3.23 (1/64) 0.3	2.94 (1/68) 0.3
Gallbladder	* (0/25) 0.0	* (0/2) 0.0	10.00 (1/32) 0.1	* (0/48) 0.1	4.03 (1/72) 0.3
Hip Prosthesis	2.13 (2/158) 0.9	0.00 (0/61) 0.4	2.13 (1/100) 0.5	9.35 (3/46) 0.3	4.01 (4/155) 1.0
Hysterectomy, Abd.	* (0/4) 0.0	* (0/4) 0.0	* (0/18) 0.1	* (0/30) 0.2	* (0/6) 0.0
Hysterectomy, Vaginal	* (0/1) 0.0	n/a	* (0/1) 0.0	* (0/8) 0.0	* (0/5) 0.0
Knee Prosthesis	4.05 (2/181) 0.5	5.00 (1/78) 0.2	0.00 (0/106) 0.3	* (0/13) 0.0	0.00 (0/110) 0.4
ORIF	0.00 (0/128) 0.6	0.00 (0/126) 0.6	0.00 (0/111) 0.7	0.00 (0/28) 0.4	0.00 (0/110) 0.6
Ovarian	* (0/9) 0.0	* (0/6) 0.0	* (0/6) 0.0	* (0/8) 0.0	* (0/13) 0.0
Rectal	* (0/10) 0.0	n/a	n/a	* (0/5) 0.1	* (0/1) 0.0
Sm Bowel	* (0/10) 0.2	* (0/2) 0.0	0.00 (0/18) 0.4	0.00 (0/28) 0.5	0.00 (0/24) 0.5
Spleen	* (0/2) 0.0	* (0/1) 0.0	* (0/3) 0.0	* (0/1) 0.0	* (0/5) 0.1

* Not enough procedures to calculate SIR

SIR > 1.0 (bad)

SIR < 1.0 (good)

TFH SSI IP SIR 2018-2021

CY/SIR ▸ Type of Procedure ▾ NHSN Abbreviation	2018 INpatient SIR Publically Reported	2019 INpatient SIR Publically Reported	2020 INpatient SIR Publically Reported	2021 (Jan-Sept) INpatient SIR Publically Reported
Appendix (APPY)	0.00 (0/47) 0.168	0.00 (0/34) 0.205	5.95 (1/16) 0.168	0.00 (0/24) 0.118
Breast (BRST)	0.00 (0/3) 0.053	0.00 (0/9) 0.151	0.00 (0/16) 0.248	0.00 (0/5) 0.042
Cesarean Section (CSEC)	1.15 (2/96) 1.080	0.00 (0/99) 1.243	0.92 (1/97) 1.080	0.00 (0/60) 0.630
Colon (COLO)	2.79 (2/16) 0.718	1.63 (1/15) 0.615	1.33 (1/21) 0.755	0.00 (0/9) 0.371
Ex Lap (XLAP)	0.00 (0/22) 0.276	0.00 (0/19) 0.224	0.00 (0/12) 0.127	0.00 (0/14) 0.158
Gallbladder (CHOLE)	0.00 (0/26) 0.172	0.00 (0/25) 0.111	0.00 (0/20) 0.109	6.90 (1/23) 0.145
Hip Prosthesis (HPRO)	1.23 (1/123) 0.815	2.06 (3/158) 1.459	0.00 (0/95) 0.685	0.00 (0/51) 0.362
Hernia (HER)	5.21 (1/18) 0.192	0.00 (0/20) 0.138	0.00 (0/22) 0.151	0.00 (0/5) 0.023
Hysterectomy, Abd. (HYST)	0.00 (0/2) 0.028	0.00 (0/4) 0.042	0.00 (0/6) 0.076	0.00 (0/3) 0.048
Hysterectomy, Vag. (VHYS)	0.00 (0/3) 0.026	0.00 (0/0)	0.00 (0/0) 0.000	0.00 (0/0) 0.000
Knee Prosthesis (KPRO)	4.12 (3/139) 0.728	1.95 (2/181) 1.027	1.6 (1/107) 0.624	3.95 (1/41) 0.253
ORIF (FX)	0.74 (1/164) 1.349	0.96 (1/128) 1.043	0.00 (0/105) 0.918	2.65 (2/117) 0.756
Ovarian (OVRY)	0.00 (0/7) 0.035	0.00 (0/9) 0.026	0.00 (0/7) 0.065	0.00 (0/8) 0.029
Rectal (REC)	0.00 (0/1) 0.036	0.00 (0/4) 0.090	0.00 (0/4) 0.149	0.00 (0/1) 0.023
Sm Bowel (SB)	1.30 (1/16) 0.567	0.00 (0/10) 0.494	1.76 (1/12) 0.567	0.00 (0/4) 0.175
Spleen (SPLE)	0.00 (0/0) 0.000	0.00 (0/2) 0.022	0.00 (0/1) 0.005	0.00 (0/1) 0.005
Cumulative	**1.64 (11/698) 6.717**	**0.999 (7/734) 7.009**	**0.85 (5/577) 5.860**	**1.24 (4/375) 1.242**

TFH SSI OP SIR

2018-2021

Year/SIR ▸ Type of Procedure ▾ NHSN Abbreviation	2018 OUTpatient SIR Not Publically Reported	2019 OUTpatient SIR Not Publically Reported	2020 OUTpatient SIR Not Publically Reported	2021 (Jan – Aug) OUTpatient SIR Not Publically Reported
Appendix (APPY)	0.00 (0/8) 0.168	0.00 (0/9) 0.036	0.00 (0/31) 0.124	0.00 (0/12) 0.048
Breast (BRST)	0.00 (0/20) 0.098	0.00 (0/48) 0.228	0.00 (0/22) 0.086	12.20 (1/19) 0.082
Ex Lap (XLAP)	0.00 (0/9) 0.010	0.00 (0/6) 0.007	0.00 (0/3) 0.003	n/a
Gallbladder (CHOLE)	0.00 (0/20) 0.015	0.00 (0/26) 0.024	0.00 (0/19) 0.012	0.00 (0/26) 0.015
Hip Prosthesis (HPRO)	0.00 (0/5) 0.007	0.00 (0/8) 0.025	0.00 (0/30) 0.042	0.00 (0/36) 0.064
Hernia (HER)	0.00 (0/86) 0.086	0.00 (0/104) 0.081	12.50 (1/86) 0.080	20.41 (1/72) 0.049
Hysterectomy, Abd. (HYST)	0.00 (0/6) 0.021	15.15 (1/17) 0.066	18.87 (1/14) 0.053	0.00 (0/7) 0.026
Hysterectomy, Vag. (VHYS)	0.00 (0/5) 0.017	0.00 (0/3) 0.010	0.00 (0/2) 0.010	0.00 (0/1) 0.003
Knee Prosthesis (KPRO)	0.00 (0/3) 0.040	0.00 (0/24) 0.274	2.19 (1/40) 0.456	2.93 (1/39) 0.341
ORIF (FX)	0.00 (0/61) 0.251	0.00 (0/73) 0.287	3.61 (1/70) 0.277	2.92 (1/89) 0.343
Ovarian (OVRY)	0.00 (0/32) 0.029	0.00 (0/32) 0.029	0.00 (0/36) 0.032	0.00 (0/18) 0.016
Cumulative	**0.00 (0/255) 0.607**	**1.07 (1/350) 0.938**	**3.40 (4/354) 1.176**	**4.05 (4/319) 0.987**

SSI Prevention Practices in Place

SSI Prevention Element	Process/Practice in Place	Update/Recommendation
Preoperative MRSA Screen Testing	Per CDPH & ID: elective orthopedic surgical inpatients with implants.	Education for Ortho clinic and RIC staff was completed in August. Process rolled out 09/07/21.
Preoperative Skin Decolonization	CHG shower night before and morning of surgery with clean clothes. Some patients use other antibacterial soap (e.g. Dial)	2% CHG wipe to op site, if CHG showers completed at home. Full body 2% CHG wipes, if CHG showers were not completed at home. Nasal & oral decolonization within 1 hour of surgery in preop. House-wide initiative for OR patients.
Intraoperative - 70% Alcohol prep	Using ChloraPrep or DuraPrep – both are alcohol based, unless contraindicated	N/A
Preop surgical site hair removal	For many patients this occurs in preop area in ASD	Education and staff reminders are ongoing to capture more; reference binder being developed
SPD – Immediate Use Steam Sterilization (IUSS)	Policy is not to IUSS implants; current IUSS rate is 0.51% (no benchmarks)	N/A

SSI Prevention Practice Opportunities

SSI Prevention Element	Process/Practice in Place	Update/Recommendation
Clinic Preoperative Optimization	Variable by clinic	Pre-Op Clinic: starting with Ortho, progressing to other specialties; BMI, HbA1c, smoking cessation, nutrition
Glycemic control (200 or 180 mg/dL), HbA1c	Individual anesthesia provider preference	HbA1c preop, glycemic control periop; Algorithm system and staff follows - anesthesia creates
BMI below 40	varies	Optimize preop
Smoking cessation	varies	Quit smoking preop, no smoking until after op area healed.
Antibiotic prophylaxis	IV abx as indicated	Use Cefazolin if PCN allergy, unless documented anaphylaxis - rare cross sensitivity. Re-dose Zosyn after 2 hours, Cefazolin after 4 hours, etc. – review during time out. If using Cleocin in place of Cefazolin, add an aminoglycoside. May be disconnect on timing documentation (some cases have documented 5-10 minutes initiation before incision).
Change gown, gloves, closure tray – bowel/colon cases	**New gown and gloves, instruments clean ***	In addition, implement fresh sterile field/instruments for closure
Wound protector	Surgeon preference	Standardize use of wound protector for open cases
Preop surgical site hair removal	**For many patients this occurs in preop area in ASD ***	Education and staff reminders are ongoing to capture more; reference binder being developed

*** Green = already in place**

Institute for Healthcare Improvement

WHITE PAPER

Framework for Effective Board Governance of Health System Quality

Content provided by:

Lucian Leape Institute, an initiative of the Institute for Healthcare Improvement, guiding the global patient safety community.

AN IHI RESOURCE

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Contents

Executive Summary

The Institute of Medicine (IOM) reports *To Err Is Human* and *Crossing the Quality Chasm* prompted health care leaders to address the patient safety crisis and advance the systems, teamwork, and improvement science needed to deliver safer care to patients.[1,2] Following the IOM reports, research on health care governance practices identified a correlation between health system board prioritization of quality oversight and higher performance on key quality indicators.[3,4,5,6,7] Quality oversight by a board has been shown to correlate with patient outcomes on key quality metrics, and boards that prioritize quality support a leadership commitment to quality and the incentives and oversight to achieve the quality care that patients deserve.

Two main evolutions have made governing quality more complex for trustees and the health system leaders who support them:

- The definition of "quality" has evolved and expanded over the last decade, from a singular focus on safety to an expanded focus on all six dimensions of quality as identified in the *Crossing the Quality Chasm* report.
- The expansion of health systems beyond hospital walls and the addition of population health oversight have created complexity both in terms of *what* to govern to support high-quality care and *how* to oversee quality outside of the traditional hospital setting and across the health care continuum.

Many health system leaders have worked to ensure that their trustees are sufficiently prepared to oversee quality, but the two factors noted above have increased the need for board education and the time commitment for trustees and the health system senior leaders who support them. Therefore, there is a need for a clear, actionable framework for better governance of quality across all dimensions, including identification of the core processes and necessary activities for effective governance of quality.

Ultimately, the most valuable resource of a board is time — both in terms of how much time they allocate and how they use it — to engage in oversight of the various areas of governance. To help health system leaders and boards use their governance time most effectively, this white paper includes three components:

- **Framework for Governance of Health System Quality:** A clear, actionable framework for oversight of all the dimensions of quality;
- **Governance of Quality Assessment:** A tool for trustees and health system leaders to evaluate and score current quality oversight processes and assess progress in improving board quality oversight over time; and
- **Three Support Guides:** Three central knowledge area support guides for governance of quality (Core Quality Knowledge, Core Improvement System Knowledge, and Board Culture and Commitment to Quality), which health system leaders and governance educators can use to advance their education for trustees.

The framework, assessment tool, and support guides aim to reduce variation in and clarify trustee responsibilities for quality oversight, and also serve as practical tools for trustees and the health system leaders who support them to govern quality in a way that will deliver better care to patients and communities.

Background

Research on health care governance practices has identified a correlation between health system board prioritization of quality oversight and higher performance on key quality indicators.[8,9,10,11,12] However, guidance and practices for board oversight of the dimensions of quality beyond safety are highly variable across health systems. Health system leaders and trustees are looking for greater depth and clarity on what they should do to fulfill their oversight of quality. Governance of quality is a long-overlooked and underutilized lever to deliver better care across all the dimensions of quality.

What to Govern as Quality: Expanding from Safety to STEEEP

The IOM report *Crossing the Quality Chasm* established six aims for improvement, a framework for health care quality in the US: care that is safe, timely, effective, efficient, equitable, and patient centered (STEEEP).[13] Safety is an essential component of quality, and health leaders have become more consistent in the governance of the elements of safety (though many health systems still do not dedicate enough time to quality or are quick to push it to the bottom of the agenda).

Yet governance of the other STEEEP dimensions of quality beyond safety is significantly more variable, providing an opportunity for greater clarity and calibration across the health care organizations and leaders that guide governance of quality. Health system leaders and trustees struggle with whether to govern a narrow definition of quality, driven by metrics defined by the Centers for Medicare & Medicaid Services (CMS) or national oversight organizations, versus governing quality's broader dimensions as put forth in the IOM STEEEP framework.

What to Govern as Quality: Expansion and Complexity of Health Systems

Health care leaders now look beyond the hospital walls to the entire system of care and to social and community factors that impact health outcomes. Thus, health system quality has expanded to include improving the health of communities and reducing the cost of health care and the financial burden facing patients. As health care is increasingly delivered in a range of settings beyond the hospital, from outpatient clinics to the home, leaders and trustees are challenged to define and govern quality in these settings.

The nationwide shift in US health care from standalone and community hospitals to larger, integrated care delivery systems has further increased the knowledge required for trustees to fulfill their fiduciary responsibility of governing quality. Finally, by tying revenue to quality performance, many payment models now add executive financial incentives to governance of quality. Health leaders have struggled to frame governance of quality in the context of the expansion and complexity of both single institutions and health systems.

Call to Action

In the 2017 report, *Leading a Culture of Safety: A Blueprint for Success,* board development and engagement was highlighted as one of the "six leadership domains that require CEO focus and dedication to develop and sustain a culture of safety."[14] According to the report, "The board is responsible for making sure the correct oversight is in place, that quality and safety data are

systematically reviewed, and that safety receives appropriate attention as a standing agenda item at all meetings."

Building on this report, the Institute for Healthcare Improvement (IHI) Lucian Leape Institute identified a need for greater understanding of the current state of governance of quality, education on quality for health system trustees, along with the potential need for guidance and tools to support governance oversight of quality. The IHI Lucian Leape Institute understood the importance of developing this forward-thinking and cutting-edge content collaboratively with leading governance organizations and making it available as a public good for all health systems to access and incorporate in a way that would be most helpful to them.

Assessment of Current Governance Practices and Education

To evaluate the current state of board governance of quality, IHI employed its 90-day innovation process.[15] This work included the following:

- **A landscape scan** to understand the current state of governance education offerings and challenges in quality, drawing on national and state trustee education programs. This scan included more than 50 interviews with governance experts, health system leaders, and trustees; and a review of available trustee guides and assessments for governance of quality.
- **A scan of existing peer-reviewed research** on board quality governance practices and the link between board practices and quality outcomes for health systems.
- **An expert meeting** (see Appendix B) attended by health care and governance experts. The meeting provided critical insights and guidance for the work, including the development of a framework for effective governance of health system quality. This group of thought leaders included representatives from the American Hospital Association (AHA), the American College of Healthcare Executives (ACHE), The Governance Institute, leading state hospital associations, health system CEOs and trustees, and national governance and health care quality experts.

Research and Landscape Scan Highlights

(Note: An in-depth assessment of the current state of board governance of quality and trustee education in support of quality is available in the companion document to this white paper, *Research Summary: Effective Board Governance of Health System Quality*.[16])

The IHI Lucian Leape Institute's research scan, evaluation of governance education in quality, and expert interviews indicated that most trustee education on governance of quality focuses primarily on safety, meaning that such education often does not prepare trustees for governing the other dimensions of quality as defined by the STEEEP framework and the IHI Triple Aim,[17] which also considers population health and health care cost. In the boardroom, quality is often a lower priority than financial oversight. Epstein and Jha found that "quality performance was on the agenda at every board meeting in 63 percent of US hospitals, and financial performance was always on the agenda in 93 percent of hospitals."[18]

Our interviews indicated that the financial and cultural implications of poor quality of care are not often formally considered, noting a difference between putting quality on a board meeting agenda and having a dedicated discussion about quality. Many trustees, while motivated to ensure high-quality care, lack a clear understanding of the necessary activities for effective quality oversight

(the "what" and "how" of their governance work); IHI's research identified the need for more direction on the core processes for governance of quality.[19] Some trustees noted that they were at the mercy of the quality data and information presented to them by their organization's leadership team; they lacked ways of confirming that their quality work was aligned with work at other leading health care organizations and industry best practice.

Health care leaders observed that the many guides and assessments they referenced often had varying recommendations for core governance activities on quality, especially for dimensions of quality beyond safety. We analyzed the available board guides or tools for board members and hospital leaders to evaluate their quality governance activities. The review of existing assessments from national and state governance support organizations identified that many focus on board prioritization of quality in terms of time spent and trustee "commitment" to governance based on a trustee self-assessment. Many assessments offer specific recommendations for key processes to oversee safety, such as reviewing serious events and key safety metrics in a dashboard. However, most assessments offer more variable guidance on the core processes to govern the STEEEP dimensions of quality beyond safety, quality outside of the hospital setting, and overall health in the communities the health systems serve.

With so many assessments and guidance recommending different processes and activities, it is not surprising that those who support trustees struggle to clearly define the core work of board quality oversight. Trustees and health care leaders alike identified a need for a simple framework that sets forth the activities that boards need to perform in their oversight of quality and for calibration across governance support organizations to support a simple, consistent framework.

Barriers to Governance of Quality

The IHI research team sought to understand and identify ways to address the many barriers to governance of quality identified in interviews and the published literature. The most common barrier identified was trustees' available time to contribute to a volunteer board. Often, health care leaders and trustees identified that expectations for trustee engagement on quality issues are not presented with the same clarity and priority as financial and philanthropic expectations for governance. Many interviewees noted that trustees are less confident in the governance of quality because of its clinical nature, which, in many cases, necessitates learning new terminology and absorbing concepts unfamiliar to trustees without a clinical background.

Many trustees and health care leaders we interviewed identified the CEO as the "gatekeeper" for the board, stewarding access to external resources and guidelines related to the board's role in health care quality, often not wanting to overwhelm or burden the trustees, given the demands on their time. However, even when the trustees and health care leaders interviewed indicated that they did have dedicated time and commitment to quality, they were not clear as to whether the specific set of processes or activities they currently had in place were the best ones for effective governance of quality.

Based on insights from IHI's research, landscape scan of current guidance on quality oversight, and extensive interviews, a new framework for governance of quality was created through a collaborative effort of thought leaders and health system leaders to provide clarity, support, and reduced variation in what boards should consider for their oversight of quality. The framework identifies the foundational knowledge of core quality concepts and the need to understand the systems for quality control and improvement used in health systems. The framework also recognizes that board culture and commitment to quality are essential.

A new Governance of Quality Assessment identifies the core processes of board governance of quality, providing a tool for boards and health system leaders to calibrate the governance oversight work plan. When these core processes are approached consistently, organizations can advance governance of quality that, based on previously cited studies, will support the health system's performance on quality.

Current State of Board Work and Education in Health System Quality

- **Governance of quality is primarily focused on safety.**

  Board education in quality is available but inconsistently accessed by trustees; education focuses primarily on safety, with variable exposure to other dimensions of quality.

- **Governance of quality is hospital-centric, with limited focus on population or community health.**

  Most board education emphasizes in-hospital quality; it does not guide boards in oversight of care in other health system settings or in the health of the community.

- **Core processes for governance of quality core are variable.**

  Board quality educational support offerings tend to emphasize general engagement in the form of time, structure, and leadership commitment to quality governance; they focus less on the specific activities (especially beyond safety) and core processes trustees need to employ to oversee quality.

- **A clear, consistent framework for governance of health system quality is needed.**

  Utilizing a consistent framework and assessment tool for key board-specific processes for quality oversight will help improve governance of health system quality and deliver on patient and community expectations for quality care.

- **A call to action to raise expectations and improve support for board governance of health system quality is needed.**

  A multifaceted approach is needed to break through the barriers to trustee oversight of quality, including a greater call to action, clearer set of core processes with an assessment of that work, and raised expectations for time to govern quality.

Framework for Governance of Health System Quality

Achieving better quality care in health systems requires a complex and multifaceted partnership among health care providers, payers, patients, and caregivers. The IHI Lucian Leape Institute's research scan, evaluation of governance education in quality, and expert interviews made it clear that board members, and those who support them, desire a clear and consistent framework to guide core quality knowledge, expectations, and activities to better govern quality. To help make progress in this area, the IHI Lucian Leape Institute convened leading governance organizations, health industry thought leaders, and trustees (see Appendix B) to collaboratively develop a new comprehensive framework and assessment tool for governance of quality.

The framework and assessment tool are designed with the following considerations:

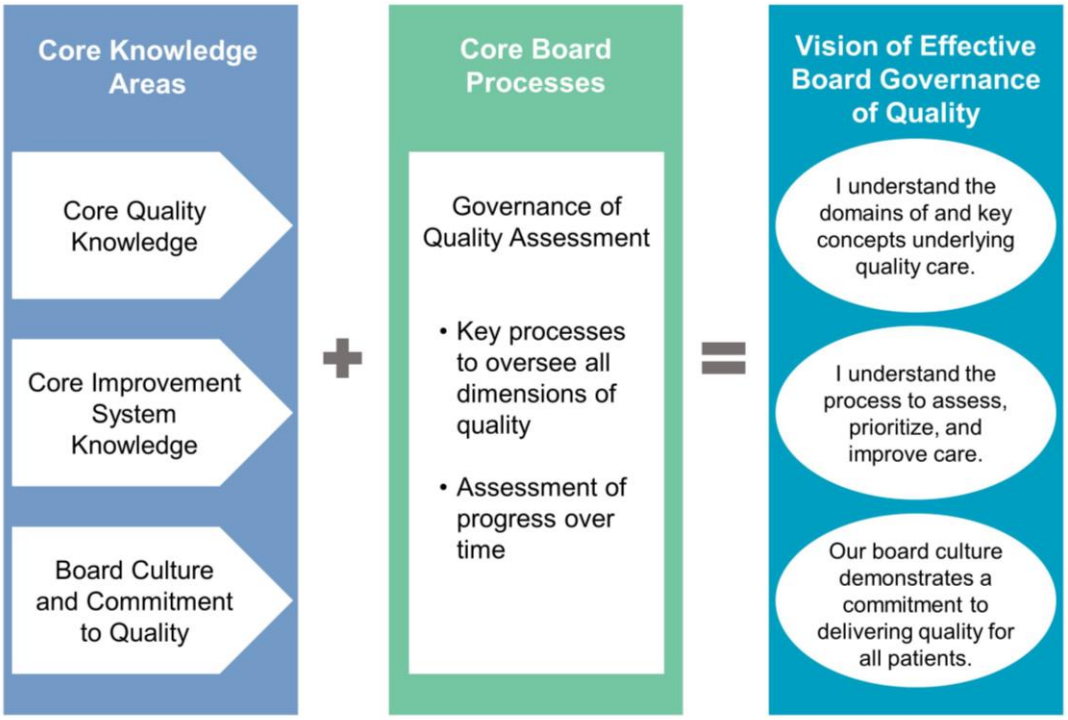
- **Simplify concepts:** Use simple, trustee-friendly language that defines actionable processes and activities for trustees and those who support them to oversee quality.
- **Incorporate all six STEEEP dimensions of quality:** Understand quality as care that is safe, timely, effective, efficient, equitable, and patient centered (STEEEP), as defined by the Institute of Medicine.
- **Include community health and value:** Ensure that population health and health care value are critical elements of quality oversight.
- **Govern quality in and out of the hospital setting:** Advance quality governance throughout the health system, not solely in the hospital setting.
- **Advance organizational improvement knowledge:** Support trustees in understanding the ways to evaluate, prioritize, and improve performance on dimensions of quality.
- **Identify the key attributes of a governance culture of quality:** Describe the elements of a board culture and commitment to high-quality, patient-centered, equitable care.

IHI worked with the expert group to establish an aspirational vision for trustees: With the ideal education in and knowledge of quality concepts, every trustee will be able to respond to three statements in the affirmative (see Figure 1).

Figure 1. Vision of Effective Board Governance of Health System Quality

Having established the vision, the expert group proceeded to define the core knowledge and core processes necessary to realize this vision, resulting in the development of a Framework for Governance of Health System Quality (see Figure 2).

Figure 2. Framework for Governance of Health System Quality



At the heart of the framework [CENTER] is the Governance of Quality Assessment (GQA), which outlines the key processes and activities that, if well performed, enable trustees to achieve the vision of effective board governance of quality [RIGHT]. The GQA serves as both a **roadmap of the key processes the board should undertake** to oversee all dimensions of quality, and an **assessment of how well the board is doing** with respect to those processes.

The expert group also identified three core knowledge areas [LEFT] that support the effective execution of the core processes and activities outlined in the GQA: Core Quality Knowledge, Core Improvement System Knowledge, and Board Culture and Commitment to Quality. The expert group's suggestions for core knowledge are assembled into three support guides (see Appendix A).

Together, the GQA and the three support guides aim to reduce variation in current governance recommendations and practices and to establish a comprehensive framework for the core knowledge and key activities for fiduciary governance of quality. Health system leadership and governance educators can use these tools to calibrate and advance their educational materials for trustees and develop ongoing education.

Patient-Centered Depiction of Quality

The expert group supported the use of a patient-centered framework, like the one introduced at Nationwide Children's Hospital in Ohio,[20] to display the core components of quality and drive home the direct impact they have on care. There is a compelling case for conveying this information to the board using a patient lens, as trustees may find the patient perspective on quality more motivating and actionable than the STEEEP terminology.

This reframed model also bundles some elements of STEEEP together in a way that represents the patient journey and avoids some of the health care terminology that can be off-putting to trustees. For example, the STEEEP dimensions of timely and efficient care are combined into "Help Me Navigate My Care." The STEEEP dimensions of equitable and patient-centered care are aggregated into "Treat Me with Respect." Figure 3 presents a visual representation of the core components of quality from the patient's perspective, with the patient at the center of the delivery system.

Figure 3. Core Components of Quality from the Patient's Perspective

*IOM STEEEP dimensions of quality: Safe, Timely, Effective, Efficient, Equitable, and Patient centered

The new framework and assessment tool will reveal areas for quality improvement to many CEOs and board members. It will take time for board members and health system leaders to incorporate those additional elements of quality into their agendas and work plans, but the changes will help to better align their quality oversight with patient expectations and the evolution, expansion, and complexity of health care delivery. Maintaining the status quo with regard to quality governance will not best serve patients or health systems, which face increasing complexity of patient-, population-, and community-based care in the coming years.

Governance of Quality Assessment: A Roadmap for Board Oversight of Health System Quality

The Governance of Quality Assessment (GQA) serves as both a **roadmap of the key processes the board should undertake** to oversee all dimensions of quality, and an **assessment of how well the board is doing** with respect to those processes. The GQA employs a set of concrete recommendations for 30 core processes of quality oversight organized into six categories, and provides a high-level assessment of board culture, structure, and commitment. The resulting GQA scores (for each core process, each category, and overall total) provide a roadmap for health care leaders and trustees to identify what to do in their work plan — and to assess their progress over time.

Most current board assessments primarily cover elements of safety, patient satisfaction, and/or board culture related to quality oversight. Most assessments do not identify the specific processes for quality oversight beyond safety and do not equally address all the dimensions of quality, including population health and care provided outside of the hospital. Variation across assessments may create confusion among trustees about what really is optimal in the oversight of quality.

The GQA aims to ensure that health system board quality oversight extends beyond the hospital to include the entire continuum of care. While many trustees understand concepts and frameworks like STEEEP and the IHI Triple Aim, they often have difficulty translating those concepts into specific activities they must perform. The GQA is specific, actionable, and tracks the processes that enable excellent quality governance. The GQA is designed for trustees and those who support them; it is written in straightforward, actionable, and trustee-centered language.

GQA Core Processes and Scoring

The Governance of Quality Assessment provides a snapshot of a total of 30 core processes organized into six categories that a board with fiduciary oversight needs to perform to properly oversee quality. The 30 core processes were developed by the expert group based on their expert opinions combined with insights gathered from more than 50 additional interviews of governance experts and health executives in the research and assessment phase of this work.

As referenced in the companion research summary to this white paper,[21] there are limited evidence-based recommendations on core processes for governance of quality beyond a few structural recommendations such as time spent, use of a dashboard, and having a dedicated quality committee. The GQA puts forth a set of core processes for governance of quality that were collaboratively developed, evaluated, and ranked at the expert meeting.

The GQA should be utilized by health systems and results tracked over time to validate the assessment's effectiveness. Certainly, there are additional quality oversight actions a board could undertake (and many already do) beyond those identified in the GQA. However, the expert group and interviewees identified the core processes in the GQA as a starting point for calibration and improvement. With a commitment to learning and improvement, and in recognition of the dynamic nature of health care, the GQA should also be revised as appropriate to incorporate the insights from new research in the boardroom.

The GQA includes a scoring system (0, 1, or 2) for trustees and health system leaders to assess the current level of performance for the 30 core processes, the six categories, and overall. Scores are totaled so that trustees and health care leaders can establish baseline scores (for each process, category, and overall) and then track their progress over time.

Bringing the GQA to the Boardroom

Health system CEOs should complete the GQA annually with their board chair and quality committee chair(s) and/or quality committee to establish a baseline for assessing their current state of oversight of quality; to identify opportunities for improvement; and to track their GQA scores over time as a measure of improving board quality oversight. It is also useful to have the senior leaders who interface with the board complete the GQA to understand and assess their role with respect to trustee oversight of quality.

Once the respondents have completed the GQA, senior leaders and trustees may choose to focus on the lowest-scoring areas to identify improvement strategies. Within larger health systems, the GQA is a useful tool to evaluate the work of multiple quality committees and create a system-wide work plan and strategies for board oversight of quality. We recommend that boards complete the GQA annually to monitor their performance and progress.

The GQA can also be used to guide discussions about which activities should be conducted at which level of governance in the case of complex systems (e.g., which processes are or should be covered in local boards, the system quality committee, and/or the overall health system board). In addition, the assessment can be used as a tool for discussion in setting agenda items for the board or quality committees.

Finally, governance educators might also use the assessment to help design their educational sessions for board members, targeting educational content to the areas where the clients need more support or education.

The expert group also recommended that the assessment tool be utilized for future research to compare how systems are performing relative to each other, collecting data longitudinally to identify which elements of the GQA are most correlated with various components of quality performance and other metrics of culture and management known to be associated with excellence.

Governance of Quality Assessment (GQA) Tool

This assessment tool was developed to support trustees and senior leaders of health systems in their oversight of quality of care by defining the core processes, culture, and commitment for excellence in oversight of quality. A guiding principle in the development of this assessment was for the board to view their role in quality oversight comprehensively in terms of the Institute of Medicine STEEEP dimensions (care that is safe, timely, effective, efficient, equitable, and patient centered) and the IHI Triple Aim.

The Governance of Quality Assessment (GQA) tool should be used to evaluate the current level of performance for 30 core processes in six categories, to identify areas of oversight of quality that need greater attention or improvement, and to track progress over time.

Instructions

The Governance of Quality Assessment organizes the health system board's quality oversight role into six categories that include a total of 30 core processes a board with fiduciary oversight should perform to effectively oversee quality.

Health system CEOs should complete the GQA annually with their board chair and quality committee chair(s) and/or quality committee.

For each item in the assessment, the person completing the assessment should indicate a score of 0, 1, or 2. Scores are then totaled for each category and overall.

Score	Description
0	**No activity:** The process is not currently performed by the board, or I am unaware of our work in or commitment to this area.
1	**Infrequent practice:** The board currently does some work in this area, but not extensively, routinely, or frequently.
2	**Board priority:** The board currently does this process well — regularly and with thought and depth.

Governance of Quality Assessment Tool (continued)

Category 1: Prioritize Quality: Board Quality Culture and Commitment		
Core Board Process	**Score (0, 1, or 2)**	**Process leads to a:**
1. Board establishes quality as a priority on the main board agenda (e.g., equivalent time spent on quality and finance), and time spent on quality reflects board commitment.		Executive committee/governing board that spends a minimum of 20% to 25% of meeting time on quality Agenda that reflects board oversight of and commitment to quality
2. Health system senior leaders provide initial and ongoing in-depth education on quality and improvement systems to all trustees and quality committee members, and clearly articulate board fiduciary responsibility for quality oversight and leadership.		Board that understands the definition of quality, key concepts, and the system of improvement used within the organization
3. Board receives materials on quality before board meetings that are appropriately summarized and in a level of detail for the board to understand the concepts and engage as thought partners.		Board that is prepared for quality oversight and engaged in key areas for discussion
4. Board reviews the annual quality and safety plan, reviews performance on quality metrics, and sets improvement aims.		Board that takes responsibility for quality and performance on quality
5. Board ties leadership performance incentives to performance on key quality dimensions.		Board that establishes compensation incentives for senior leaders linked to prioritizing safe, high-quality care
6. Board conducts rounds at the point of care or visits the health system and community to hear stories directly from patients and caregivers to incorporate the diverse perspectives of the populations served.		Board that sets the tone throughout the organization for a culture of teamwork, respect, and transparency and demonstrates an in-person, frontline, board-level commitment to quality
7. Board asks questions about gaps, trends, and priority issues related to quality and is actively engaged in discussions about quality.		Board that engages in generative discussion about quality improvement work and resource allocation
Category 1 Total Score: (14 possible)		

Governance of Quality Assessment Tool (continued)

Category 2: Keep Me Safe: Safe Care		
Core Board Process	**Score (0, 1, or 2)**	**Process leads to a:**
1. Board regularly tracks and discusses performance over time on key safety metrics (including both in-hospital safety and safety in other settings of care).		Board that reviews management performance on key safety metrics and holds management accountable for areas where performance needs to be improved
2. Board annually reviews management's summary of the financial impact of poor quality on payments and liability costs.		Board that understands the financial costs of poor safety performance
3. Board evaluates management's summary of incident reporting trends and timeliness to ensure transparency to identify and address safety issues.		Board that holds management accountable to support staff in sharing safety concerns to create a safe environment of care for patients and staff
4. Board reviews Serious Safety Events (including workforce safety) in a timely manner, ensuring that leadership has a learning system to share the root cause findings, learning, and improvements.		Board that holds management accountable for a timely response to harm events and learning from harm
5. Board reviews management summary of their culture of safety survey or teamwork/safety climate survey to evaluate variations and understand management's improvement strategies for improving psychological safety, teamwork, and workforce engagement.		Board that holds management accountable for building and supporting a culture of psychological safety that values willingness to speak up as essential to patient care and a collaborative workplace
6. Board reviews required regulatory compliance survey results and recommendations for improvement.		Board that performs its required national (e.g., CMS, Joint Commission, organ donation) and state regulatory compliance oversight
Category 2 Total Score: (12 possible)		

Governance of Quality Assessment Tool (continued)

Category 3: Provide Me with the Right Care: Effective Care		
Core Board Process	**Score (0, 1, or 2)**	**Process leads to a:**
1. Board ensures that the clinician credentialing process addresses concerns about behavior, performance, or volume and is calibrated across the health system.		Board that understands its fiduciary responsibility of credentialing oversight to ensure the talent and culture to deliver effective patient care
2. Board reviews trends and drivers of effective and appropriate care as defined for the different areas of the system's care.		Board that holds leadership accountable to ensure that the system does not underuse, overuse, or misuse care
3. Board evaluates senior leaders' summary of metrics to ensure physician and staff ability to care for patients (e.g., physician and staff engagement, complaint trends, staff turnover, burnout metrics, violence).		Board that holds senior leaders accountable for the link between staff engagement and wellness with the ability to provide effective patient care
4. Board establishes a measure of health care affordability and tracks this measure, in addition to patient medical debt, over time.		Board that understands that cost is a barrier for patients, and that health systems are accountable to the community to ensure affordable care
Category 3 Total Score: (8 possible)		

Governance of Quality Assessment Tool (continued)

Category 4: Treat Me with Respect: Equitable and Patient-Centered Care		
Core Board Process	**Score (0, 1, or 2)**	**Process leads to a:**
1. Board has patient representation, patient stories, and/or interaction with patient and family councils, and engagement with community advocates at every board and quality committee meeting.		Board that connects its quality oversight role with direct patient experiences to build understanding of issues and connection to patients
2. Board reviews patient-reported complaints and trends in patient experience and loyalty that indicate areas where respectful patient care is not meeting system standards.		Board that reviews senior leadership's approach to evaluating, prioritizing, and responding to patient concerns and values a patient's willingness to recommend future care
3. Board evaluates and ensures diversity and inclusion at all levels of the organization, including the board, senior leadership, staff, providers, and vendors that support the health system.		Board that supports and advances building a diverse and culturally respectful team to serve patients
4. Board reviews the health system's approach to disclosure following occurrences of harm to patients and understands the healing, learning, and financial and reputational benefit of transparency after harm occurs.		Board that understands the link between transparency with patients after harm occurs and a culture of learning and improvement in the health system
5. Board ensures that all patient populations, especially the most vulnerable, are provided effective care by evaluating variations in care outcomes for key conditions or service lines based on race, gender, ethnicity, language, socioeconomic status/payer type, and age.		Board that holds senior leaders accountable for health equity (making sure all patients receive the same quality of care) and prioritizes closing the gaps in outcomes that are identified as disparities in care
Category 4 Total Score: (10 possible)		

Governance of Quality Assessment Tool (continued)

Category 5: Help Me Navigate My Care: Timely and Efficient Care		
Core Board Process	**Score (0, 1, or 2)**	**Process leads to a:**
1. Board reviews metrics related to access to care at all points in the system (e.g., hospital, clinics, behavioral health, nursing home, home care, dental) and ensures that access is equitable and timely for all patients.		Board that oversees senior leadership's strategy to improve care access (e.g., time and ability to get an appointment, wait time for test results, delays) for all patients
2. Board reviews senior leadership's strategy for and measurement of patient flow, timeliness, and transitions of care, and evaluates leadership's improvement priorities.		Board that evaluates the complexity of care navigation for patients and monitors senior leadership's work to integrate care, reduce barriers, and coordinate care (e.g., delays, patient flow issues) to support patients
3. Board evaluates senior leadership's strategy for digital integration and security of patient clinical information and its accessibility and portability to support patient care.		Board that holds senior leaders accountable for a strategy to support patients' digital access, security, and portability of clinical information
Category 5 Total Score: (6 possible)		

Governance of Quality Assessment Tool (continued)

Category 6: Help Me Stay Well: Community and Population Health and Wellness		
Core Board Process	**Score (0, 1, or 2)**	**Process leads to a:**
1. Board reviews community health needs assessment and senior leadership's plans for community and population health improvement.		Board that oversees the development of a community health needs assessment and has identified which population health metrics are most relevant to track for its patients (e.g., asthma, diabetes, stroke, cancer screening, flu vaccine, dental, prenatal, opioid overuse, obesity, depression screening) Board holds senior leaders accountable for reaching goals established to improve key community health issues
2. Board reviews performance in risk-based contracts for population health.		Board that evaluates performance on risk-based contracts for populations and strategies for improvement
3. Board evaluates approach to integration and continuity of care for behavioral health patients.		Board that holds senior leaders accountable for integrating care and tracking care coordination data to support screening, access, and follow-up
4. Board reviews leadership's plans to address social determinants of health, including any plans for integration with social and community services.		Board that understands the essential nature of wraparound services to support the wellness of certain patient populations and oversees the strategic integration with those service providers
5. Board evaluates the health system's strategy for supporting patients with medically and socially complex needs and with advance care planning.		Board that ensures senior leaders evaluate high-utilization groups and key drivers to help those users navigate and manage their care
Category 6 Total Score: (10 possible)		

Total Score for This Assessment: **(sum of total scores for Categories 1 through 6)**	
Total Possible Score:	**60**

Interpreting the Overall Governance of Quality Assessment Score

Total Score	Board Performance Level
40 to 60	Advanced board commitment to quality
25 to 40	Standard board commitment to quality
25 or Fewer	Developing board commitment to quality

Using GQA Results to Plan Next Steps

After completing the Governance of Quality Assessment, the CEO, board chair, and board quality chair(s) should review the results and use them as the basis for planning next steps.

- **Review the spectrum of GQA scores:** Are the results similar across your board and committees? Compare the variation of scores across your board, quality committee(s), and senior leaders. If there is high variation in scores, it may be an opportunity to consider clarifying expectations and the work plan for quality oversight.
- **Aggregate GQA scores to identify areas for improvement:** Aggregating the GQA scores (overall and for each category) establishes a baseline score to evaluate the current areas of oversight and identify opportunities to better oversee the dimensions of quality that have lower scores. Could the board agenda or work plan be adjusted to make time to address other quality items (i.e., those with low GQA scores)?
- **Set a target GQA score for next year:** Set a target and a plan for improving the GQA score annually. Focus on the elements of the GQA where you have the greatest gap or that are of the most strategic importance to your organization.

We recommend that boards and leadership teams also evaluate time spent discussing quality and trustee confidence in their knowledge of basic quality concepts in tandem with the GQA.

- **Evaluate time allocation to quality:** Track how much time the board spends each meeting discussing quality. Does the time commitment indicate that quality has equal priority in time and attention with finance? Is quality just an item on the agenda without discussion?
- **Use the GQA to identify board education opportunities:** Review both the initial education and the ongoing education of board members on quality. What topics in the framework and GQA are not covered? Do you provide trustees with supplementary reading, useful articles, and educational opportunities in the areas identified in the GQA?

Conclusion

Excellence in quality must be supported from the bedside to the boardroom; patients deserve nothing less. Health system boards are deeply committed to the patients and communities they serve; however, trustees often require support in order to best understand and fulfill their fiduciary responsibility and commitment to the patients and communities they serve. Trustee knowledge of quality and improvement concepts is essential to their governance role. To be effective, trustees must also pair this knowledge with an effective board culture and a clear set of activities that support oversight of quality.

The framework, assessment tool, and support guides presented in this white paper were created through collaboration with leaders in health care and governance. The immediate goal of these resources is to reduce variation in board oversight of quality and to provide an improved roadmap for health system trustees. The ultimate goal is to ensure that oversight of quality of care for all patients is supported by more effective board education in quality concepts, clarity of core processes for trustee governance of quality, and a deeper board commitment to quality.

Appendix A: Support Guides

The expert group identified three core knowledge areas for effective governance of quality: first, a familiarity with all dimensions of quality; second, an understanding of how improvement occurs in systems; and third, an appreciation of the importance of demonstrating a commitment to quality through the board culture.

Appendix A includes support guides for these three core knowledge areas:

Support Guide: Core Quality Knowledge

The medical terms, health care oversight organizations and processes, and clinical concepts that arise in quality work are often unfamiliar to board members without a medical background, unlike other areas of oversight such as finance. Initial and ongoing education in quality concepts is essential to providing trustees with the necessary context and knowledge for thoughtful engagement.

This support guide is designed to guide hospital leaders and trustee educators in taking the guesswork out of the core quality concepts that are needed to prepare trustees for governance of quality across *all* dimensions and *all* care settings.

The expert group recommended providing governance education to trustees via a simple, patient-centered framework, just as the Governance of Quality Assessment consolidates and clarifies core board processes for governance of quality from the STEEEP dimensions of quality into a patient-centered framework. See Figure 3 (above), which presents the patient at the center of governance quality work, a visual that the expert group found compelling.

All new trustees, not just quality committee members, need to receive a thorough introduction to quality. To oversee quality, board members need fluency in many concepts, which should be introduced in a layered manner (similar to building a scaffold) to avoid overwhelming trustees. An overarching framework that shows how all these elements are necessary for patient care helps connect the dots and build commitment.

Table 1 presents the foundational concepts for board oversight of quality recommended by the expert group, organized by the STEEEP dimensions of quality (care that is safe, timely, effective, efficient, equitable, and patient centered) represented through a patient lens.

Table 1. Foundational Concepts for Board Core Quality Knowledge

Quality Concept	Key Questions	Suggested Educational Concepts
Basic Quality Overview	• What is quality in health care? • What are the benefits of quality? • What are the costs of poor quality? • Who oversees the elements of quality in our organization?	• Brief overview of quality in health care • STEEEP dimensions of quality presented through a patient lens • IHI Triple Aim • Benefits of quality • "Cost" of poor quality: Financial, patients, staff • Quality strategy, quality management • Overview of risk-/value-based care • Structures for quality reporting, assessment, and improvement • Structure for CEO/leadership evaluation
Keep Me Safe *Safe*	• What is safety? • What is a culture of safety? • What are surveys of patient safety culture? • What is "harm"? • What are the types of harm? • How do you decide if an adverse outcome is preventable harm? • How do we learn about harm in a timely manner? • What is our response to harm (i.e., what actions do we take when harm occurs)? • What are the financial and reputational costs of harm? • How do we reduce, learn from, and prevent harm? • How do we track harm in our system and in the industry?	• Preventable harm vs. adverse outcome • Just Culture and culture of safety • Science of error prevention and high reliability • Classification of the types of harm • Knowing about harm: Incident reporting, claims, grievances • Response to harm: Root cause analysis/adverse event review, patient apology and disclosure, legal, learning systems • Costs of harm: Claims/lawsuits, penalties, ratings, reputational, human emotional impact • Harm terminology: HAC, SSI, falls, ADE, employee safety, etc. • Regulatory oversight of safety

Quality Concept	Key Questions	Suggested Educational Concepts
Provide Me with the Right Care *Effective*	• How do we ensure that our health system properly diagnoses and cares for patients to the best evidence-based standards in medicine? • How does leadership oversee whether approaches to care vary within our system? • How do we identify the areas where care is not to our standards? • How do we identify the areas where care is meeting or exceeding our standards? • How do we attract and retain talent to care for patients?	• Evidence-based medicine • Overview of staff and physician recruitment, credentials/privileges, training, retention (burnout, turnover, violence) • Overview of standard of care concept and issues/processes that lead to variation • Trends in care utilization and clinical outcomes • Key care outcomes to be evaluated through an equity lens: race, ethnicity, gender, language, and socioeconomic status
Treat Me with Respect *Equitable and Patient centered*	• How do we evaluate patients' satisfaction and feedback? • What is "equitable care" and how do we evaluate it? • Do some patient groups have worse outcomes? Why? • What is our staff diversity and how may it impact patient care? • How do we ensure that patients are partners in their care? • How do we reduce cost of care? • How do we track medical debt for patient groups?	• Patient satisfaction and patient grievances (e.g., HCAHPS[22]) • Patient-centered care • Care affordability, debt burden • Social determinants of health • Pricing and affordability of care bundles • Total costs of care for conditions • Medical debt concerns/trends • Value-based payment models
Help Me Navigate My Care *Timely and Efficient*	• What do care navigation and care access mean? • What issues result from waiting for care or disconnected care (care that is not timely or efficient)? • Which populations have more complex care needs? What do we do to help them navigate care? • What is the role of a portable medical record and health IT in supporting care navigation?	• Care access, efficiency, and drivers of care navigation • Define "continuum of care" • Focus on key areas that are "roadblocks" in care navigation and their drivers • Define electronic health record, health IT, and the systems to support and secure patient information and patient access

Quality Concept	Key Questions	Suggested Educational Concepts
Help Me Stay Well *Community and Population Health and Wellness*	• What is the difference between population and patient health? • How do we segment patient populations to evaluate population health outcomes? • What unique strategies do/can we deploy to care for and engage areas or populations with worse health outcomes? • How are we compensated (or not) for population health and wellness?	• Define population health vs. patient health[23] • Explain the community health needs assessment (CHNA) • Interpret population health, prevention, and wellness metrics • Define social determinants of health • Explain fee-based vs. risk-based contracts

This support guide can be used as a starting point for hospital leaders and educators to create their system's board education plan, to ensure the concepts are imparted across the dimensions of health care quality to trustees. Health systems will vary in terms of which concepts need to be introduced to all trustees versus only to those who serve on the quality committee. That said, absorbing all these concepts at once would be overwhelming, so teaching the concepts in smaller segments over time is essential, as is reinforcing the concepts with additional learning opportunities and available resources, particularly as new members join the board.

It is also worthwhile to consider different formats for teaching these concepts to various audiences such as a half-day retreat, a full-day education session, or in-depth hour-long programs offered throughout the year. Finally, consider how the concepts should be introduced to new trustees and reinforced for experienced trustees to support a common knowledge base.

Just as most trustees join a board with a conversation about what they can contribute in time, treasure, and talent to support the organization, perhaps there can also be a "learn" expectation to identify the need for continuous growth and learning, even as a trustee, to advance a culture of improvement and quality excellence.

Support Guide: Core Improvement System Knowledge

A 2016 IHI White Paper, *Sustaining Improvement*, identified the drivers of quality control and quality improvement in high-performing organizations and highlighted that boards play an essential role in creating a culture of quality care and quality improvement.[24] Quality knowledge for trustees must include a deep understanding of and comfort with how health system leaders will identify, assess, and improve the elements of care delivery.

Organizations might take many approaches to improvement — from Total Quality Management, to Lean, to high reliability, to the Model for Improvement. Trustees need to understand their health system's improvement methodology and ensure that the health system has the people, processes, and infrastructure to support its improvement efforts.

Trustees might ask health system leaders the following discussion questions to gain an understanding of the organization's improvement system:

- What is the organization's system of improvement, in terms of both evaluating performance and prioritizing areas for improvement?
- How were major quality improvement efforts selected in the last two years? What criteria were used and evaluated to measure their impact?
- How does quality improvement cover the entire health system versus in-hospital improvement only?
- What analytic methods do leaders use to gather insight from the entire system to inform improvement initiatives? What are the gaps in the information and analytics?
- Recognizing that quality improvement is most sustainable when frontline staff members are engaged, how do senior leaders ensure that frontline staff lead quality improvement work, are actively providing ideas for improvement, and are willing and encouraged to speak up?

Health care leaders may educate board members on their organization's improvement system in many ways. For example:

- Virginia Mason Health System board members travel to Japan to learn about the Toyota Production System and Lean principles that Virginia Mason also employs.[25]
- The pediatric improvement network called Solutions for Patient Safety dedicates significant effort to board education on their high-reliability method of improvement and the board's role in understanding the core knowledge of safety and analyzing performance.[26]
- The board at St. Mary's General Hospital in Kitchener, Ontario, "sought out new knowledge about Lean through board education sessions, recruited new members with expertise in Lean and sent more than half of the board to external site visits to observe a high-performing Lean healthcare organization."[27]

Boards must understand how health system leaders perform the functions of quality planning, quality control, and quality improvement throughout the organization — and how that quality work is prioritized and resources are allocated. A 2015 article describes the process that Johns Hopkins Medicine undertook to ensure that the health system could map accountability for quality improvement throughout the organization, from the point of care to the board quality committee.[28] Similarly, in an article for The Governance Institute's *BoardRoom Press*, leaders from Main Line

Health shared their effort to delineate the flow and tasks of the oversight of quality from the boardroom to the frontline operations.[29] While the Johns Hopkins and Main Line Health approaches are unique to their systems, the essential idea they advanced is that a board and leadership should define the components of quality improvement work in their system and identify the accountability for those components throughout the system.

In addition to understanding accountability for quality throughout a health system, it is also essential for trustees to develop analytical skills to review data and engage meaningfully with leadership in generative dialogue about trends in the data. As part of their quality oversight role, health system boards need to understand the organization's key metrics and periodically review areas of performance that are outside of or below established expectations.

Also, educational training for trustees should teach them how to review data over time and request that data be benchmarked against other leading organizations to help them evaluate improvement opportunities. In IHI's interviews, some trustees noted that the way data are presented often impacts their ability to gain insights to oversee and engage leaders in discussions on quality performance and progress of quality improvement efforts.

In her work with health system trustees, Maureen Bisognano, IHI President Emerita and Senior Fellow, challenges boards that they should be able to answer four analytic questions pertaining to quality:[30]

1. Do you know how good you are as an organization?
2. Do you know where your variation exists?
3. Do you know where you stand relative to the best?
4. Do you know your rate of improvement over time?

A board that understands management's system of improvement and is analytically capable of tracking performance will be able to confidently answer those four questions. The board plays a critical role in holding health system leaders accountable for improvement results and should be a thought partner in the system's quality improvement efforts. Understanding the system of improvement and the ways in which an organization identifies and prioritizes areas for improvement is an essential function of quality governance.

Support Guide: Board Culture and Commitment to Quality

A board that understands quality concepts and the organization's system of improvement may still be unable to fulfill its commitment to safe, high-quality, and equitable patient care if it does not also have a culture of commitment to quality and a structure that ensures that the quality functions are effectively carried out. Essential elements of board culture and commitment to quality are incorporated in the Governance of Quality Assessment in recognition that a board that governs quality must not only know the key processes to oversee quality, but also oversee them in a way that demonstrates a cultural commitment to quality.

Many individuals and organizations have contributed thought leadership on building a culture for governance of quality in health care, including leading governance experts (such as Jim Conway, James Reinertsen, Larry Prybil, and James Orlikoff), The Governance Institute, the American Hospital Association, and a few leading state hospital associations. With guidance from the expert group, this support guide focuses on elements of governance culture, structure, and commitment that are unique to supporting trustee oversight of and engagement in quality.

The expert group identified five high-level attributes of board culture and commitment to quality, as described below.

Set Expectations and Prioritize Quality

Quality needs to be a priority for all board members, not completely delegated to the quality committee(s), even if the quality committee is doing more of the oversight. Quality is demonstrated as a board priority in many ways, including dedicating time to engage in discussion about quality issues on board meeting agendas, and linking some component of executive compensation to performance on quality metrics.

For example, before a trustee joins the Virginia Mason Health System board, they are sent a compact (that is then reviewed annually) to reinforce core expectations of trustees, which includes quality oversight.[31] Stephen Muething, Co-Director, James M. Anderson Center for Health System Excellence, Cincinnati Children's Hospital Medical Center, notes that Cincinnati Children's initially assigns all new board members to serve on the quality committee for their first year on the board, indicating that quality is so essential to their operations that every board member must develop core knowledge in quality.

Still, for too many boards, quality is not central to trustee education and not allocated sufficient time for learning and generative discussion.

Build Knowledge Competency and Define Oversight Responsibility of Quality

Knowledge and a clear work plan form a foundation for confident and thoughtful engagement in quality. Once trustees have been educated and are confident in their understanding of the core concepts, health system leaders need to work with trustees to define which issues the quality committee(s) will manage and which issues will be discussed by the entire board. This delineation of activities needs to be clearly articulated in the annual work plan for each group and will vary based on the size, scope, and structure of each organization.

Create a Culture of Inquiry

Board oversight of quality is not intended to micromanage the work of senior leaders, but to engage in thoughtful inquiry to ensure that organizational performance aligns with the expectations established by both leaders and trustees. For example, Henry Ford Health System has an annual quality retreat for its board quality committee and the quality committees of its hospitals and business lines. The trustees and health system leaders use this retreat as a time to dive deep on education, evaluate performance in depth, and have small group discussions to evaluate both quality and governance practices.[32]

Diversity also adds to the culture of inquiry by bringing differing perspectives and community representation to the quality discussions. The size of board and committee meetings can prohibit in-depth dialogue; building in time for small group interactions can help support a culture of inquiry.

Be Visible in Supporting Quality

Boards can support health system leaders in their efforts to improve quality in many ways, including conducting rounds, visiting the point of care, and thanking frontline staff for their contributions to improving care quality and safety. Health system leaders can provide guidance on the best ways for trustees to be visible in supporting quality in the organization.

Focus on the Patient

The board can also support quality work by including time on the agenda to hear patient stories, which personalizes the data. For example, board chair Mike Williams described how "Children's National Medical Center in Washington, DC, has strengthened board engagement with their frontline clinical teams to focus on safety, quality, and outcomes of clinical care. Their 'board to bedside' sessions discuss important topics of care and then move to the bedside to experience how changes are being implemented and gather experiences of patients."[33]

The elements of this support guide are reinforced in the Board Quality Culture and Commitment section (Category 1) of the Governance of Quality Assessment (GQA). Boards that carry out the core processes of governance of quality without a deeper culture and commitment to quality will be more likely to have a "check the box" mentality that the expert group identified as less likely to demonstrate leadership and commitment to advancing quality within the health system in a way that patients deserve.

Appendix B: IHI Lucian Leape Institute Expert Meeting Attendees

Advancing Trustee Engagement and Education in Quality, Safety, and Equity

July 12, 2018

- Paul Anderson, Trustee, University of Chicago Medical Center
- Evan Benjamin, MD, MS, FACP, Chief Medical Officer, Ariadne Labs; Harvard School of Public Health; Harvard Medical School; IHI Faculty
- Jay Bhatt, DO, Senior Vice President and Chief Medical Officer, American Hospital Association; President, Health Research & Educational Trust
- Lee Carter, Member, Board of Trustees, Former Board Chair, Cincinnati Children's Hospital Medical Center
- Jim Conway, MS, Trustee, Winchester Hospital, Lahey Health System
- Tania Daniels, PT, MBA, Vice President, Quality and Patient Safety, Minnesota Hospital Association
- James A. Diegel, FACHE, Chief Executive Officer, Howard University Hospital
- James Eppel, Executive Vice President and Chief Administrative Officer, HealthPartners
- Karen Frush, MD, CPPS, Chief Quality Officer, Stanford Health Care
- Tejal K. Gandhi, MD, MPH, CPPS, Chief Clinical and Safety Officer, Institute for Healthcare Improvement; President, IHI Lucian Leape Institute (Meeting Co-Chair)
- Michael Gutzeit, MD, Chief Medical Officer, Children's Hospital of Wisconsin
- Gerald B. Hickson, MD, Senior Vice President for Quality, Safety, and Risk Prevention, Vanderbilt Health System; Joseph C. Ross Chair for Medical Education and Administration, Vanderbilt University Medical School; Board Member, Institute for Healthcare Improvement
- Brent James, MD, MStat, Member, National Academy of Medicine; Senior Fellow and Board Member, Institute for Healthcare Improvement
- Maulik Joshi, DrPH, Chief Operating Officer, Executive Vice President, Integrated Care, Anne Arundel Medical Center
- Gary S. Kaplan, MD, FACMPE, Chairman and CEO, Virginia Mason Health System; Chair, IHI Lucian Leape Institute; Board Member, Institute for Healthcare Improvement
- John J. Lynch III, FACHE, President and CEO, Main Line Health
- Kedar Mate, MD, Chief Innovation and Education Officer, Institute for Healthcare Improvement
- Patricia McGaffigan, RN, MS, CPPS, Vice President, Safety Programs, Institute for Healthcare Improvement; President, Certification Board for Professionals in Patient Safety, IHI
- Ruth Mickelsen, JD, MPH, Board Chair, HealthPartners

- Stephen E. Muething, MD, Chief Quality Officer, Co-Director, James M. Anderson Center for Health System Excellence, Cincinnati Children's Hospital Medical Center
- Lawrence Prybil, PhD, LFACHE, Community Professor, College of Public Health, University of Kentucky
- Michael Pugh, MPH, President, MDP Associates; Faculty, Institute for Healthcare Improvement
- Shahab Saeed, PE, Adjunct Professor of Management, Gore School of Business, Westminster College; Former Trustee, Intermountain Healthcare
- Carolyn F. Scanlan, Board Member, Penn Medicine Lancaster General Health
- Michelle B. Schreiber, MD, former Senior Vice President and Chief Quality Officer, Henry Ford Health System
- Andrew Shin, JD, MPH, Chief Operating Officer, Health Research & Educational Trust
- Debra Stock, Vice President, Trustee Services, American Hospital Association
- Charles D. Stokes, MHA, FACHE, President and CEO, Memorial Hermann Health System; Immediate Past Chair, American College of Healthcare Executives
- Beth Daley Ullem, MBA, Lead Author and Faculty, IHI; President, Quality and Patient Safety First; Trustee, Solutions for Patient Safety and Catalysis; Former Trustee, Thedacare and Children's Hospital of Wisconsin; Advisory Board, Medstar Institute for Quality and Safety
- Sam R. Watson, MSA, MT(ASCP), CPPS, Senior Vice President, Patient Safety and Quality, and Executive Director, MHA Keystone Center for Patient Safety and Quality, Michigan Health & Hospital Association; Board Member, Institute for Healthcare Improvement
- John W. Whittington, MD, Senior Fellow, Institute for Healthcare Improvement
- Kevin B. Weiss, MD, MPH, Senior Vice President, Institutional Accreditation, Accreditation Council for Graduate Medical Education
- David M. Williams, PhD, Senior Lead, Improvement Science and Methods, Institute for Healthcare Improvement
- Isis Zambrana, Associate Vice President, Chief Quality Officer, Jackson Health System

Appendix C: Members of the IHI Lucian Leape Institute

- Gary S. Kaplan, MD, FACMPE, Chairman and CEO, Virginia Mason Health System; Chair, IHI Lucian Leape Institute; Board Member, Institute for Healthcare Improvement
- Tejal K. Gandhi, MD, MPH, CPPS, Chief Clinical and Safety Officer, Institute for Healthcare Improvement; President, IHI Lucian Leape Institute
- Donald M. Berwick, MD, MPP, President Emeritus and Senior Fellow, Institute for Healthcare Improvement
- Joanne Disch, PhD, RN, FAAN, Professor ad Honorem, University of Minnesota School of Nursing
- Susan Edgman-Levitan, PA, Executive Director, John D. Stoeckle Center for Primary Care Innovation, Massachusetts General Hospital
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- David Michaels, PhD, MPH, Professor, Department of Environmental and Occupational Health, Milken Institute School of Public Health, George Washington University
- Julianne M. Morath, RN, MS, President and CEO, Hospital Quality Institute of California
- Susan Sheridan, MIM, MBA, DHL, Director of Patient Engagement, Society to Improve Diagnosis in Medicine
- Charles Vincent, PhD, MPhil, Professor of Psychology, University of Oxford; Emeritus Professor of Clinical Safety Research, Imperial College, London
- Robert M. Wachter, MD, Professor and Chair, Department of Medicine, Holly Smith Distinguished Professor in Science and Medicine, Marc and Lynne Benioff Endowed Chair, University of California, San Francisco

Emeritus Members

- Carolyn M. Clancy, MD, Assistant Deputy Under Secretary for Health for Quality, Safety and Value, Veterans Health Administration, US Department of Veterans Affairs
- Amy C. Edmondson, PhD, AM, Novartis Professor of Leadership and Management, Harvard Business School
- Lucian L. Leape, MD, Adjunct Professor of Health Policy, Harvard School of Public Health
- Paul O'Neill, 72nd Secretary of the US Treasury

References

[1] Institute of Medicine. *To Err Is Human: Building a Safer Health System*. Washington, DC: The National Academies Press; 2000.

[2] Institute of Medicine Committee on Quality of Health Care in America. *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, DC: National Academies Press; 2001.

[3] Jha AK, Epstein AM. A survey of board chairs of English hospitals shows greater attention to quality of care than among their US counterparts. *Health Affairs*. 2013;32(4):677-685.

[4] Jha A, Epstein A. Hospital governance and the quality of care. *Health Affairs*. 2010;29(1):182-187.

[5] Jiang HJ, Lockee C, Bass K, Fraser I, Norwood EP. Board oversight of quality: Any differences in process of care and mortality? *Journal of Healthcare Management*. 2009;54(1):15-30.

[6] Mannion R, Davies HTO, Jacobs R, Kasteridis P, Millar R, Freeman T. Do hospital boards matter for better, safer, patient care? *Social Science & Medicine*. 2017;177:278-287.

[7] Tsai TC, Jha AK, Gawande AA, Huckman RS, Bloom N, Sadun R. Hospital board and management practices are strongly related to hospital performance on clinical quality metrics. *Health Affairs*. 2015;34(8):1304-1311.

[8] Jha AK, Epstein AM. A survey of board chairs of English hospitals shows greater attention to quality of care than among their US counterparts. *Health Affairs*. 2013;32(4):677-685.

[9] Jha A, Epstein A. Hospital governance and the quality of care. *Health Affairs*. 2010;29(1):182-187.

[10] Jiang HJ, Lockee C, Bass K, Fraser I, Norwood EP. Board oversight of quality: Any differences in process of care and mortality? *Journal of Healthcare Management*. 2009;54(1):15-30.

[11] Mannion R, Davies HTO, Jacobs R, Kasteridis P, Millar R, Freeman T. Do hospital boards matter for better, safer, patient care? *Social Science & Medicine*. 2017;177:278-287.

[12] Tsai TC, Jha AK, Gawande AA, Huckman RS, Bloom N, Sadun R. Hospital board and management practices are strongly related to hospital performance on clinical quality metrics. *Health Affairs*. 2015;34(8):1304-1311.

[13] Institute of Medicine Committee on Quality of Health Care in America. *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, DC: National Academies Press; 2001.

[14] American College of Healthcare Executives and IHI/NPSF Lucian Leape Institute. *Leading a Culture of Safety: A Blueprint for Success*. Boston, MA: American College of Healthcare Executives and Institute for Healthcare Improvement; 2017. www.ihi.org/resources/Pages/Publications/Leading-a-Culture-of-Safety-A-Blueprint-for-Success.aspx

[15] Martin LA, Mate K. *IHI Innovation System*. IHI White Paper. Boston, Massachusetts: Institute for Healthcare Improvement; 2018. www.ihi.org/resources/Pages/IHIWhitePapers/IHI-Innovation-System.aspx

[16] Daley Ullem E, Gandhi TK, Mate K, Whittington J, Renton M, Huebner J. *Research Summary: Effective Board Governance of Health System Quality*. Boston, MA: Institute for Healthcare Improvement; 2018. www.ihi.org/resources/Pages/IHIWhitePapers/Framework-Effective-Board-Governance-Health-System-Quality.aspx

[17] Berwick DM, Nolan TW, Whittington J. The Triple Aim: Care, health, and cost. *Health Affairs*. 2008;27(3):759-769.

[18] Jha A, Epstein A. Hospital governance and the quality of care. *Health Affairs*. 2010;29(1):182-187.

[19] Brown A, Dickinson H, Kelaher M. Governing the quality and safety of healthcare: A conceptual framework. *Social Science & Medicine*. 2018;202:99-107.

[20] Brilli RJ, Allen S, Davis JT. Revisiting the quality chasm. *Pediatrics*. 2014;133(5):763-765.

[21] Daley Ullem E, Gandhi TK, Mate K, Whittington J, Renton M, Huebner J. *Research Summary: Effective Board Governance of Health System Quality*. Boston, MA: Institute for Healthcare Improvement; 2018. www.ihi.org/resources/Pages/IHIWhitePapers/Framework-Effective-Board-Governance-Health-System-Quality.aspx

[22] HCAHPS: Patients' Perspectives of Care Survey. Centers for Medicare & Medicaid Services. www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/HospitalHCAHPS.html

[23] Pathways to Population Health. www.pathways2pophealth.org/index.html

[24] Scoville R, Little K, Rakover J, Luther K, Mate K. *Sustaining Improvement*. IHI White Paper. Cambridge, MA: Institute for Healthcare Improvement; 2016. www.ihi.org/resources/Pages/IHIWhitePapers/Sustaining-Improvement.aspx

[25] Remarks from Gary Kaplan, MD, Chairman and CEO, Virginia Mason Health System, at the expert meeting on July 12, 2018.

[26] Interviews with: Anne Lyren, MD, MSc, Clinical Director, Children's Hospitals' Solutions for Patient Safety, on November 10, 2017; Stephen Muething, MD, Chief Quality Officer, Co-Director, James M. Anderson Center for Health System Excellence, Cincinnati Children's Hospital Medical Center, on October 27, 2017.

[27] Shilton D, Sluka J, Toussaint JS. Improving governance through principles. *Healthcare Executive*. 2018;33(4):68-70.

[28] Pronovost PJ, Armstrong M, Demski R, et al. Creating a high-reliability health care system: Improving performance on core processes of care at Johns Hopkins Medicine. *Academic Medicine*. 2015;90(2):165-172.

[29] Murphy DM. The board's role in quality and patient safety performance measurement. *BoardRoom Press*. 2014;25(3):5-11.

[30] "What Healthcare Leaders Need to Know Now." FurstGroup Blog. July 18, 2013. www.furstgroup.com/blog/leadership-bisognano

[31] Remarks from Gary Kaplan, MD, Chairman and CEO, Virginia Mason Health System, at the expert meeting on July 12, 2018.

[32] Interview with Michelle Schreiber, MD, former Senior Vice President and Chief Quality Officer, Henry Ford Health System, on January 25, 2018.

[33] Interview with Michael Williams, MBA, Board Chair, Children's National Medical Center, on February 8, 2018.

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

RISK:

Organizations who respond reactively, instead of proactively, 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 low quality care and poor patient outcomes.

POLICY:

The purpose of the Quality Assessment/Performance Improvement (QA/PI) plan is to provide a framework for promoting and sustaining performance improvement at Tahoe Forest Health System, in order to improve the quality of care and enhance organizational performance. An effective Quality Assessment/Performance Improvement (QA/PI) plan will proactively 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 service excellence, and High Reliability principles to promote and improve patient safety. Tahoe Forest Health System has an established mission, vision, values statement, and utilizes a foundation of excellence model, which are used to guide all improvement activities.

MISSION STATEMENT

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

VISION STATEMENT

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

VALUES STATEMENT

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

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

FOUNDATIONS OF EXCELLENCE

A. Our foundation of excellence includes: Quality, Service, People, Finance and Growth.
    1. Quality – provide excellence in clinical outcomes
    2. Service – best place to be cared for
    3. People – best place to work, practice, and volunteer

4. Finance – provide superior financial performance
5. Growth – meet the needs of the community

PERFORMANCE IMPROVEMENT INITIATIVES

A. The 2022 performance improvement priorities are based on the principles of STEEEP™, (Safe, Timely, Effective, Efficient, Equitable, Patient Centered Care) and the Quadruple Aim:
   1. Improving the patient experience of care (including quality and satisfaction);
   2. Improving the health of populations;
   3. Reducing the per capita cost of health care;
   4. Staff engagement and joy in work.

B. Priorities identified include:
   1. Exceed national benchmark with quality of care and patient satisfaction metric results with a focus on process improvement and performance excellence
      a. Striving for the Perfect Care Experience
      b. Identify and promote best practice and evidence-based medicine
      c. Focus on CMS quality star rating improvements, within the 7 measure groups, that fall below benchmark
   2. Continued focus on quality and patient/employee safety during the pandemic, following CDC, State, and County Health guidelines, and utilizing the following strategies:
      a. Strengthen the system and environment
      b. Support patient, family, and community engagement and empowerment
      c. Improve clinical care
      d. Reduce harm
      e. Boost and expand the learning system
   3. Ongoing survey readiness, and compliance with federal and state regulations, resulting in a successful triennial General Acute Care Hospital Relicensing (GACHLRS) survey
   4. Sustain a culture of safety, transparency, accountability, and system improvement
      a. Continued participation in Beta HEART (Healing, Empathy, Accountability, Resolution, Trust) program
      b. Conduct annual Culture of Safety SCORE (Safety, Culture, Operational, Reliability, and Engagement) survey
      c. Continued focus on the importance of event reporting
   5. Focus on our culture of safety, across the entire Health System, utilizing High Reliability Organizational thinking
      a. Proactive, not reactive
      b. Focus on building a strong, resilient system
      c. Understand vulnerabilities
      d. Recognize bias
      e. Efficient resource management
      f. Evaluate system based on risk, not rules
   6. Emphasis on achieving highly reliable health care through the following:
      a. A commitment to the goal of zero harm
      b. A safety culture, which ensures employees are comfortable reporting errors without fear of retaliation
      c. Incorporate highly effective process improvement tools and methodologies into our work flows
      d. Ensure that everyone is accountable for safety, 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. Event reporting platform upgrade with a focus on creating a best practice user-friendly system that promotes reporting.
9. Promote lean principles to improve processes, reduce waste, and eliminate inefficiencies
10. Identify gaps in the Epic electronic health record system upgrade and develop plans of correction
11. Maximize Epic reporting functionality to improve data capture and identification of areas for improvement as part of our data governance strategy.

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

ORGANIZATION FRAMEWORK

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

Governing Board

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

Administrative Council

A. Administrative Council creates an environment that promotes the attainment of quality and process improvement through the safe delivery of patient care, quality outcomes, and patient satisfaction. The Administrative Council sets expectations, develops plans, and manages processes to measure, assess, and improve the quality of the Health System’s governance, management, clinical and support activities.
B. Administrative Council ensures that clinical contracts contain quality performance indicators to measure the level of care and service provided.
C. Administrative Council has developed a culture of safety by embracing High Reliability tenets and

has set behavior expectations for providing Safe, Timely, Effective, Efficient, Equitable, Patient Centered Care (STEEEP^{TM}), supporting Triple Aim, and ensures compliance with regulatory, statutory, and contractual requirements.

Board Quality Committee

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

Medical Executive Committee

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

Department Chairs of the Medical Staff

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

Medical Staff

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

Hospital Management (Directors, Managers, and Supervisors)

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

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

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

Employees

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

PERFORMANCE IMPROVEMENT STRUCTURE

Medical Staff Quality Assessment Committee

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

The Medical Staff Quality Assessment Committee:

A. Annually review and approve the Medication Error Reduction Plan (MERP), Infection Control Plan, Environment of Care Management Program, Utilization Review Plan, Risk Management Plan, Trauma Performance Improvement Plan, and the Patient Safety Plan.
B. Regularly reviews progress to the aforementioned plans.
C. Reviews quarterly quality indicators to evaluate patient care and delivery of services and takes appropriate actions based on patient and process outcomes;
D. Reviews recommendations for performance improvement activities based on patterns and trends

identified by the proactive risk reduction programs and from the various Health System committees;

E. Elicits and clarifies suspected or identified problems in the provision of service, quality, or safety standards that may require further investigation;
F. Reviews and approves chartered Performance Improvement Teams as recommended by the Performance Improvement Committee (PIC). Not all performance improvement efforts require a chartered team;
G. Reviews progress reports from chartered teams and assists to address and overcome identified barriers;
H. Reviews summaries and recommendations of Event Analysis/Root Cause Analysis (RCA) and Failure Mode Effects Analysis (FMEA) activities.
I. Oversees the radiation safety program, including nuclear medicine and radiation oncology and evaluates the services provided and make recommendations to the MEC.
J. Oversees the Infection Control, Pharmacy & Therapeutics, and Antibiotic Stewardship program and monitors compliance with their respective plans.
K. Oversees the Trauma Program and monitors compliance with the Trauma Performance Improvement plan.

Performance Improvement Committee (PIC)

A. Medical Staff Quality Assessment Committee provides direct oversight for the PIC. PIC is an executive committee with departmental representatives within the Tahoe Forest Health System, presenting their QA/PI findings as assigned. The goal of this committee is to achieve optimal patient outcomes by making sure that all staff participate in performance improvement activities. Departmental Directors, or their designee, review assigned quality metrics biannually at the PIC (See Attachment C – QA PI Reporting Measures). Performance improvement includes collecting data, analyzing the data, and taking action to improve. Director of Quality and Regulations is responsible for processes related to this committee.
B. The Performance Improvement Committee will:
    1. Oversee the Performance Improvement activities of TFHS including data collection, data analysis, improvement, and communication to stakeholders
    2. Set performance improvement priorities and provide the resources to achieve improvement
    3. 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;
    4. Report the committee's activities quarterly to the Medical Staff Quality Committee.

SCIENTIFIC METHOD FOR IMPROVEMENT ACTIVITIES

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

Performance Improvement Teams

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

PERFORMANCE IMPROVEMENT EDUCATION

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

PERFORMANCE IMPROVEMENT PRIORITIES

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

DESIGNING NEW AND MODIFIED PROCESSES/FUNCTIONS/SERVICES

A. Tahoe Forest Health System designs and modifies processes, functions, and services with quality in mind. When designing or modifying a new process the following steps are taken:
    1. Key individuals, who will own the process when it is completed, are assigned to a team led by the responsible individual.
    2. An external consultant is utilized to provide technical support, when needed.
    3. The design team develops or modifies the process utilizing information from the following concepts:

a. It is consistent with our mission, vision, values, and strategic priorities and meets the needs of individual served, staff and others
b. It is clinically sound and current
c. Current knowledge when available and relevant, i.e., practice guidelines, successful practices, information from relevant literature and clinical standards
d. It is consistent with sound business practices
e. It incorporates available information and/or literature from within the organization and from other organizations about potential risks to patients, including the occurrence of sentinel/near-miss events, in order to minimize risks to patients affected by the new or redesigned process, function, or service
f. Conducts an analysis, and/or pilot testing, to determine whether the proposed design/redesign is an improvement and implements performance improvement activities, based on this pilot
g. It incorporates the results of performance improvement activities
h. It incorporates consideration of staffing effectiveness
i. It incorporates consideration of patient safety issues
j. It incorporates consideration of patient flow issues

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

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

PROACTIVE RISK ASSESSMENTS

A. Risk assessments are conducted to proactively 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 Effect Mode Analysis (FMEA) will be completed based on the organization's assessment and current trends in the health care industry, and as approved by PIC or the MS QAC.
    2. The Medical Staff Quality Committee and other leadership committees will recommend the processes chosen for our proactive risk assessments based on literature, errors and near miss events, sentinel event alerts, and the National Quality Forum (NQF) Endorsed Set of Safe Practices.
        a. The process is assessed to identify steps that may cause undesirable variations, or “failure modes”.
        b. For each identified failure mode, the possible effects, including the seriousness of the effects on the patient are identified and the potential breakdowns for failures will be prioritized.
        c. Potential risk points in the process will be closely analyzed, including decision points and patient’s moving from one level of care to another through the continuum of care.
        d. For the effects on the patient that are determined to be “critical”, an event analysis/root cause analysis is conducted to determine why the effect may occur.
        e. The process will then be redesigned to reduce the risk of these failure modes

occurring or to protect the patient from the effects of the failure modes.
   f. The redesigned process will be tested and then implemented. Performance measurements will be developed to measure the effectiveness of the new process.
   g. Strategies for maintaining the effectiveness of the redesigned process over time will be implemented.
3. Ongoing hazard surveillance rounds, including Environment of Care Rounds and departmental safety hazard inspections, are conducted to identify any trends and to provide a comprehensive ongoing surveillance program.
4. The Environment of Care Safety Officer and EOC/Safety Committee review trends and incidents related to the Safety Management Plans. The EOC Safety Committee provides guidance to all departments regarding safety issues.
5. The Infection Preventionist and Environment of Care Safety Officer, or designee, complete a written infection control and preconstruction risk assessment for interim life safety for new construction or renovation projects.

DATA COLLECTION

A. Tahoe Forest Health System chooses processes and outcomes to monitor based on the mission and scope of care and services provided and populations served. The goal is 100% compliance with each identified quality metric. Data that the organization considers for the purpose of monitoring performance includes, but is not limited to, adverse patient events, which includes the following:
   1. Medication therapy
   2. Adverse event reports
   3. National Quality forum patient safety indicators
   4. Infection control surveillance and reporting
   5. Surgical/invasive and manipulative procedures
   6. Blood product usage, including transfusions and transfusion reactions
   7. Data management
   8. Discharge planning
   9. Utilization management
   10. Complaints and grievances
   11. Restraints/seclusion use
   12. Mortality review
   13. Medical errors including medication, surgical, and diagnostic errors; equipment failures, infections, blood transfusion related injuries, and deaths due to seclusion or restraints
   14. Needs, expectations, and satisfaction of individuals and organizations served, including:
      a. Their specific needs and expectations
      b. Their perceptions of how well the organization meets these needs and expectations
      c. How the organization can improve patient safety?
      d. The effectiveness of pain management
   15. Resuscitation and critical incident debriefings
   16. Unplanned patient transfers/admissions
   17. Medical record reviews
   18. Performance measures from acceptable data bases/comparative reports, i.e., RL Datix Event Reporting, Quantros RRM, NDNQI, HCAHPS, Care Compare, QualityNet, HSAG HIIN, MBQIP, 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 radio nuclides and radiopharmaceuticals, including the radionuclide's identity, the date received, method of receipt, activity, recipient's identity, date administered, and disposal
5. Reports of required reporting to federal, state, authorities
6. Performance measures of processes and outcomes, including measures outlined in clinical contracts

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

AGGREGATION AND ANALYSIS OF DATA

A. Tahoe Forest Health System believes that excellent data management and analysis are essential to an effective performance improvement initiative. Statistical tools are used to analyze and display data. These tools consist of dashboards, bar graphs, pie charts, run charts (SPC), histograms, Pareto charts, control charts, fishbone diagrams, and other tools as appropriate. All performance improvement teams and activities must be data driven and outcome based. The analysis includes comparing data within our organization, with other comparable organizations, with published regulatory standards, and best practices. Data is aggregated and analyzed within a time frame appropriate to the process or area of study. Data will also be analyzed to identify system changes that will help improve patient safety and promote a perfect care experience (See Attachment D for QI PI Indicator definitions).

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

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

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

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

REPORTING

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

CONFIDENTIALITY AND CONFLICT OF INTEREST

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

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

ANNUAL ASSESSMENT

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

PLAN APPROVAL

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

Related Policies/Forms:

Medication Error Reduction Plan, APH-34

Medication Error Reporting, APH-24

Infection Control Plan, AIPC-64

Environment of Care Management Program, AEOC-908

Utilization Review Plan (UR), DCM-1701

Risk Management Plan , AQPI-04

Patient Safety Plan, AQPI-02

Emergency Operations Plan (Comprehensive), AEOC-17

Employee Health Plan, DEH-39

Trauma Performance Improvement Plan

Discharge Planning, ANS-238

References:

HFAP and CMS

FINAL RECOMMENDATIONS

FUTURE OF RURAL HEALTH CARE TASK FORCE

MAY 2021

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Caribou, ME

Nancy Agee
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Terry Scoggin
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Cape Fear Valley Hoke Healthcare
and Valley Bladen Healthcare
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and Hills Markets
Rapid City, SD

EXECUTIVE SUMMARY

As we write this report in December 2020, health care providers across the nation are working around the clock to battle the COVID-19 pandemic. More than 2.2 million rural residents have tested positive since the beginning of the pandemic — 15.6% of U.S. cases, even though rural residents represent only 14% of the overall population.[1] With cases and hospitalizations surging, hospitals and health care providers have worked tirelessly to respond to the growing demand for care. In rural areas, with fewer providers of both primary and specialty care, the situation has been doubly challenging.

> We've been waving the flag for years about vulnerability in rural hospitals. The pandemic really exposed those gaps in the system.
>
> – Member Observation at December 2020 Rural Health Care Task Force Meeting –

Rural providers have stepped up despite those challenges. Not only have rural hospitals taken the lead in testing and public health messaging in their own communities, but many have also received patients from urban hospitals overwhelmed with complex COVID cases.

Against this backdrop, the Future of Rural Health Care Task Force met regularly to focus on long-range solutions for rural health care while simultaneously immersed in the crisis of the pandemic. Convened by the American Hospital Association in July 2019, the group of 28 rural hospital CEOs and state hospital association executives was charged with exploring the challenges and strengths in rural hospitals and identifying and developing bold solutions and promising practices to help ensure ongoing access to care for the 60 million[2] U.S. residents who live in rural areas. The critical nature of their task became more evident as COVID-19 quickly revealed weaknesses in our health care system, especially in rural areas.

Envisioning Rural Health Care Transformation

In early 2019, the American Hospital Association (AHA) released "Rural Report: Challenges Facing Rural Communities and the Roadmap to Ensure Local Access to High-quality, Affordable Care." The report identified the obstacles and opportunities in rural health care and laid out a roadmap for action, including proposed federal policies and investments to support rural hospitals and communities.[3]

But, as the 2019 report acknowledged, federal policy alone will not ensure the future of rural health care. Creative thinking and innovation on a state, community and institutional level are essential to the operational transformation of rural health care in America — as well as the improved health of rural residents.

The Future of Rural Health Care Task Force was tasked with envisioning a range of bold solutions and promising practices to achieve that transformation. This report is the result of that visioning process. It depicts the landscape of rural health care today, then describes a set of innovative solutions and promising practices for care delivery as well as financial models to ensure the financial stability of rural hospitals and access to care for rural residents.

The four innovative solutions include:

1. **Public-private Funding for Core Services.** Recognizing that some of the most essential health care services in rural areas are also costly to deliver because of geography and low population density, the Task Force proposes a new funding system by which public and private payers pool funds to pay for a defined set of essential services to a particular community. Designed in collaboration with payers, providers and communities themselves, this bold solution reframes both health and health care, promotes preventive care, addresses the social determinants of health and builds a community investment in improving health and health outcomes.

2. **Flexible Funding Programs to Support Rural Hospital Infrastructure Transformation.** Rural hospitals face a perennial problem: low patient volumes drive up the cost of care delivery while low reimbursement rates necessitate thin margins. As a result, rural hospitals often do not have access to the capital needed to maintain and adapt infrastructure, including buildings, clinical equipment and technology. The Task Force recommends developing new ways to fund infrastructure by promoting existing resources (e.g., Community Development Financial Institutions and other government programs and philanthropic opportunities), while building regional collaborations with other providers to develop complementary rather than competitive services. The eventual goal would be to develop a rural health care infrastructure that blends people, processes and technology and allows for clinical transformation across facilities and specialties to deliver appropriate care regardless of location.

3. **Create a Rural Design Center Within CMMI.** Established in 2010 by the Patient Protection and Affordable Care Act, CMMI tests innovative payment and delivery models to improve quality of care while lowering costs. However, rural hospitals rarely meet the patient volumes and other requirements for participation in these programs. Creating a Rural Design Center would provide CMMI with the expertise and insights necessary for developing programs to adapt existing projects to a rural framework and also give rural hospitals the opportunity to innovate on the local level.

4. **Grant-Writing Gig Economy.** Government agencies, non-profit organizations and philanthropic groups have grant programs available for health care organizations, including those in rural areas. However, many rural facilities do not have the staff time or expertise necessary to successfully apply for, receive and manage grant funds. An online platform and corresponding app that matches rural hospitals with qualified grant writers may help smaller facilities secure funding for needed services and programs.

In addition to these four innovative solutions, the Task Force identified eight promising practices — programs and initiatives already underway in parts of the country — that should be scaled up and spread nationally to support rural hospitals. These include:

1. **Global Budget Payment Model.** Global Budget Payment Models — like the Pennsylvania Rural Health Model and All Payer ACOs in Maryland and Vermont — have been credited with providing a more reliable funding stream that gives hospitals more flexibility and allows greater innovation in times of need.

2. **Rural Hospital Federal Tax Credit Program.** In Georgia, the Rural Hospital Tax Credit Program, which took effect in 2017, has increased donations to rural hospitals by offering donors a tax credit (rather than a tax deduction) on their

state taxes. Expanding this tax credit program nationally with a federal tax credit can provide essential funds to support to rural hospitals in all states, including those without state income taxes.

3. **Telemedicine.** The rapid adoption of telemedicine during the COVID-19 pandemic has highlighted both the benefits and the obstacles connected with effective deployment, especially in rural areas. Addressing regulatory obstacles (relaxed during the pandemic but not permanently) and promoting underutilized resources can help build this capability nationally.

4. **Strategic Partnerships and Affiliations.** Models are evolving for new types of partnerships and affiliations that achieve objectives for both rural and urban organizations and revitalize healthcare delivery in rural areas. Options exist short of acquisition, including clinical affiliation or hospital management or telemedicine arrangements. By building on their role as connectors in their communities, rural hospitals can optimize the services they offer while becoming more sustainable and more effectively addressing challenges that affect patient care.

5. **Broadband and Mobile Technology.** Increasing availability of broadband and/or high-speed mobile networks holds the potential to improve health care delivery and health monitoring for a broad swath of the country. Broadband and mobile technology – including texts; video and audio calls; and apps – can help providers expand their scope of services, extend their service area and provide more reliable connectivity.

6. **Leadership.** Rural communities need an investment in transformational leadership development for health care leaders; visionary leaders are critical to innovation and sustained change in rural health care. Training programs specifically targeted to health care administrators, hospital board members and others can help create and transform health care systems in rural areas.

7. **Rural Philanthropy.** Integrating philanthropy into a hospital's strategic plan should be a part of a long-term trajectory to promote investments in the health of a community. Forming long-term partnerships with funders and building relationships over time can lead to more funding opportunities and more secure financial footing for rural hospitals.

8. **Maternal Health.** Increasing national awareness of maternal health outcomes — and disparities among different racial/ethnic groups – in the U.S. provide an opportunity to expand current models and best practices that hold promise. These include increasing access to doula services, targeting and improving outcomes for high-risk women and instituting group prenatal care appointments to improve engagement and information sharing among pregnant women.

The solutions needed in rural health care are not one-size-fits-all. Rural America is not a monolith, but a patchwork of unique communities and populations. Recognizing this reality, the Task Force created these solutions and highlighted these promising practices because they can be tailored to the contexts of rural hospitals and the communities they serve.

Likewise, ensuring the future of rural health care is not the responsibility of any one segment or stakeholder in rural health care. Collaboration and contributions at all levels — facility, community, non-profit and corporate, state and federal governments — are necessary to implement these proposed solutions and to continue to inspire and sustain innovations that promote the health of rural residents and their communities.

INTRODUCTION

In 2019, the American Hospital Association brought together a group of 28 rural hospital CEOs and state hospital association executives from clinical and non-clinical backgrounds to form AHA's Future of Rural Health Care Task Force. The goal was to build out expertise in long-term strategic policy planning for rural health care and develop sustainable approaches and actionable solutions to finance and deliver care in rural settings. Led by Board Chair Kris Doody R.N., CEO of Cary Medical Center in Caribou, Maine, the group represents independent and system-owned hospitals, as well as different Medicare designations, including critical access hospitals.

In 2019, the group knew the task ahead would be difficult. In 2020, they faced even greater challenges than they could have imagined as the COVID-19 pandemic ravaged the country, sending health care institutions from coast to coast into crisis mode.

After the launch of the Task Force, members were interviewed between July and October 2019 to collect their early insights about the charge and vision for the work ahead. A few themes emerged:

- Desire for strategies and solutions they could put to work in their communities
- Cultivate collaborative relationships with their peers
- Learn about the roles and capacities of fellow Task Force members' organizations
- Develop a clearer understanding of policy options to address the needs of rural health care

The Task Force has worked (both during meetings and in separate interview/pre-work sessions) to refine and finalize comprehensive solutions that address the well documented needs in rural health care and that build a pathway toward sustainable care delivery and financing mechanisms.

AHA staff captured the content from Task Force discussions and curated them into recommendations. We received additional input from the Leadership Forum, an external group of 16 leading voices working on rural health issues, who offered diverse perspectives, expertise and broad thought leadership on the proposed solutions that emerged from Task Force deliberations. The Task Force has continued to show resiliency in creating long-range solutions, despite the challenge of looking beyond the short-term in the midst of a fluctuating pandemic.

> Rural hospitals should lead as a community convener and/or convening partner to leverage the collaborative, resilient, and resourceful nature of their communities, local businesses, regional partners and payers. Flexible solutions should result in vibrant, healthy communities with equal and seamless access to essential health care services that are sustainably funded, safe for the patient and health care workforce, and appropriate.
>
> – AHA Future of Rural Health Care Task Force –

BACKGROUND

The United States rural health care system provides services to 60 million people: roughly one in five residents of this country.[4] For the most part, these services are provided by rural hospitals and health systems, institutions that are central to their local community and culture. Delivering health care in rural areas has never been easy, but the challenges to these institutions have increased and intensified in recent years, leading to a crisis that must be addressed.

Rural hospitals are often the first point of contact in the health care system for rural communities. They hold the opportunity to guide, coordinate and build patient experiences that connect community members to their

care. Rural communities are resilient, self-reliant and adept at optimizing resources, even when scarce. Knit by close relationships, rural hospitals form strong bonds across agencies and sectors, often bringing together people of diverse backgrounds and beliefs through the common interest in a healthy, vibrant population.

Rural hospitals are an economic anchor in their communities as direct employers, and purchasers of services and driver of economic activity. The availability of local access to health care is an important factor for businesses considering whether to invest or locate in a particular area. Moreover, private sector employment generated by rural hospitals supports a strong tax base, which funds services such as public education, fire, police and road maintenance.[5] This status contributes to the influence of rural hospitals, but also adds to the pressures they experience and the responsibility they feel for their communities and neighbors.

When Task Force members were asked to describe strengths of rural communities, several key takeaways emerged:

- **Community.** Rural hospitals embody the principles of collaboration and the importance of relationships as a core strength.
- **Culture.** Rural hospitals are diverse, resilient and nimble. Independent and proud, rooted in heritage, faith and purpose, they find purpose in providing high quality health care to their neighbors, family members and friends.
- **Challenges.** The same environment that creates close relationships and builds tight communities can also produce isolation and lead to limited resources. Many rural communities face difficult economics and tough workforce challenges. Low hospital volumes, inadequate payer mix and dependence on government payers are directly linked to these challenges.

The unique nature of the challenges in rural health care are well-documented. Some challenges are persistent (such as negative operating margins stemming from disproportionate dependence on Medicare and Medicaid); others are more recent (such as a shift from inpatient to outpatient care that for rural hospitals has meant lagging revenue); as well as emerging challenges (such as the opioid crisis, which is particularly acute in rural settings).[3]

Among the more pressing challenges:

- **Hospital Closures.** The need for quality care close to home does not go away when rural hospitals close. 134 rural hospitals have closed since 2010.[6] The National Rural Health Association estimates that one third of rural hospitals are at risk for closure.[7] A 2015 report found that hospital closures led to losses ranging from $902,000 to $9.5 million in wages, salaries and benefits for rural residents.[8]
- **Shortage of Health Care Workers.** The majority of designated Health Professional Shortage areas are rural, according to U.S. Department of Health and Human Services (HHS). According to the National Rural Health Association, the patient-to-primary care physician ratio in rural areas is only 39.8 physicians per 100,000 people, compared with 53.3 physicians per 100,000 in urban areas.[9,10]
- **Challenging Reimbursement Models.** Rural hospital's revenue depends primarily on reimbursement from Medicare and Medicaid, which sometimes lags behind private payers. About 40% of rural hospitals have negative operating margins. Exemplified by the ACA, the recent shift to reward value, rather than volume, of care has not helped the situation. Many rural hospitals are too small, financially tenuous, technologically bereft or understaffed to benefit from programs instituted as part of this legislation, according to a 2016 report by the HHS about rural hospital participation in value-based purchasing programs.[11] Shifting care to

ambulatory settings only exacerbates already low inpatient volumes in rural hospitals.[12]

- **Overall Mortality Rate.** Mortality rates for the five leading causes of death — heart disease, cancer, unintentional injury, lower respiratory disease and stroke — are all higher in rural areas. Research shows that the mortality disparities between urban and rural areas have been growing in recent decades. Studies show that mortality rises in areas where hospitals have recently shuttered.

The pandemic only compounded rural hospitals' ongoing concerns with financial viability. Since March 2020, hospitals have been forced to interrupt or defer elective services and increase spending on personal protective equipment and other equipment, leading to intensified pressure on already thin margins.[13] Across the country, rural facilities have stepped up to coordinate local response, organizing testing, corralling PPE supplies and marshalling public awareness campaigns to flatten the curve and save lives.[14]

As the pandemic wreaked havoc, rural hospitals rose to the occasion — simultaneously highlighting the challenges they face and the potential they hold for addressing the health care needs of rural residents in the United States. Rural hospitals are not only critical sources of health care and healing, they are also the hearts of their communities, pumping economic vitality and leadership into rural areas.

SOLUTIONS

Public-Private Funding for Core Services

Background

A central role of rural hospitals is to provide medically appropriate care close to patients' homes. Communities need ready access to core, essential services like emergency and specialty care, regardless of how frequently those services are used. Specialized medical services that provide care for emergency conditions such as trauma and major injury, strokes, complications related to labor and delivery and heart attacks are extremely time-sensitive and must be easily accessible to avoid preventable deaths. In addition, convenient access to routine specialty care for chronic conditions is necessary to supporting patient care plans. Providing the right care at the right time in the right setting is key to improving outcomes, yet for too many rural residents, essential services are not accessible or reliably available close to home.

Barriers to care in rural areas include distance and transportation, health insurance coverage, poor health literacy, social stigma and privacy issues and workforce shortages.[15] Another major factor is the current reimbursement system and the tenuous financial viability of rural hospitals. Hospital closures in rural areas are on the rise.[16]

Payment for health care services in most areas of the country is currently tied to volume, which is often unstable and unpredictable, especially in rural areas. Lack of consistent funding threatens access to essential services and undermines the health and health outcomes of rural residents.

Rural health care's affordability, geographic proximity and overall quality are less than that found in non-rural areas.[17] Significantly, some of the most difficult-to-access services are among the most needed in rural areas, including mental health and substance use services to address high rates of suicide and opioid overdose. There is also the pressing need for home health, hospice and palliative care for older residents and those with multiple chronic diseases.

Core Essential Services

The Task Force identified the following core essential services:

- Primary Care
- Psychiatric and substance use treatment
- ED, EMS and observation care
- Maternal care
- Transportation
- Diagnostics
- Home Care
- Dental
- Robust Referral System
- Telehealth

The lack of these services — combined with significant low-income populations without health insurance or access to primary care — has led to substantial increases in rural emergency department (ED) utilization for semi-urgent care, further compromising continuity and quality of care. Rural EDs are less likely to be staffed by emergency medicine physicians and more likely to be staffed by family medicine or internal medicine physicians. Rural EDs are also sometimes staffed by advanced practice providers such as nurse practitioners and physician assistants.

The current fee-for-service (FFS) model — which rewards volume as opposed to value — puts rural hospitals at an inherent disadvantage due to their unstable and unpredictable volumes. FFS models can unintentionally force providers to focus on income-generating services to sustain their facilities, rather than the core services that the community needs but must be operated as a loss. By moving to a value-based care environment, payers can utilize "fixed" payments as a tool to help providers focus on delivering care without prioritizing revenue-generating services.

A recent Viewpoint published in the *Journal of the American Medical Association* explained how rural hospitals that are participating in the Pennsylvania Rural Health Model were able to respond to the rapidly evolving COVID-19 pandemic public health crisis.[18] Those hospitals reported that capitated payments — a feature of the model — offered them a protective factor against the reduction in services experienced during the first wave of the pandemic. (The Pennsylvania Rural Health Model is discussed more on page 22).

There is growing acknowledgment that payment policies that offer more predictable, stable funding provide flexibilities for providers to focus on providing the right care to the right patient at the right time. The Task Force believes that creating public-private funding pools to cover core services would improve access to care while spreading the expenditures across all payers in a market.

Solution

The Task Force recommends setting up a system by which public and private payers pool funds to pay for a defined set of core, essential services, such as emergency services or obstetrics.

This would allow rural institutions to establish a reliable and adequate funding flow for essential services while easing reliance on volume-based income sources. Payments to the fund would be tied to each payer's market share in that region.

Using funds from the pool, each participating hospital would hire a care coordinator/navigator to ensure that patients have access to core services while preventing overuse. The program would also involve the local community and individual patients in devising ways that patients with insufficient health insurance coverage can earn credits toward care and build a culture of health and an investment in wellness.

Below are the key features of this solution from each group's perspective.

Payers:

- Payers and hospitals identify and agree upon core, essential services and quality measures for beneficiaries' care.
- Payers provide funds to providers to cover these core services for the community on a population, not volume-driven, basis.

- Payers must commit to three years of participation. Any payers who opt to leave a market within that time period must pay a pre-determined penalty to the fund. Penalties should be severe enough to discourage early withdrawal.

Hospitals:

This solution would provide flexible funding that hospitals can use to 1) ensure access to the agreed-upon core services and 2) provide care coordination and navigation services for patients who have trouble accessing care or who are high-utilizers of services.

This is a variation on the care coordination model that is often focused on a particular service line (such as emergency room use) or condition (such as diabetes or cancer) and may allow coverage of services not traditionally considered to be health care, such as transportation, food and housing. Other examples of flexible spending include hiring a physician on salary, utilizing Certified Nurse Midwives (CNMs) for OB care and providing health care consults via telehealth.

Care coordinators/navigators can be used to help high-utilizer patients meet their health care needs while reducing unnecessary utilization.

- Hospitals will be accountable for meeting negotiated quality measures related to core services rendered. If quality measures are not met, payers could reduce future allocations. Importantly, hospitals would still receive full funding for any time period in which they don't meet their quality measures. They wouldn't have to issue refunds to payers but would receive less funding during the following period.
- Hospitals can choose to invest in the services and/or health-promoting activities that best meet the community's needs and achieve quality outcomes, even if those services fall outside traditional health care (such as housing, transportation and healthy food).

Individuals and Patients:

The goal should be to convey the message that prevention and wellness carry tangible benefits for individuals and communities.

To ensure access to care for uninsured or under-insured populations, programs would devise a sliding fee scale or equivalent donation of time/resources/investment in

Rural Emergency Hospital (REH) Designation

In December 2020, the House and Senate approved the Consolidated Appropriations Act, 2021 – legislation that includes roughly $900 billion in COVID-19 relief and a number of provisions beneficial to hospitals and health systems.

The legislation establishes a REH designation under the Medicare program that will allow existing facilities to meet a community's need for emergency and outpatient services without having to provide inpatient care. Emergency services would be provided 24 hours a day, 365 days a year, and communities would have the flexibility to align additional outpatient and post-acute services with community needs. REH's will receive a fixed monthly payment plus a 5% add-on to the Outpatient Prospective Payment System (PPS) rate for outpatient services. The fixed monthly payment will be 1/12th of the average annual payment critical access hospitals received in excess of the PPS (for all services – inpatient, outpatient, skilled nursing facility) in 2019. The fixed amount will be adjusted each year by the hospital market-basket update.

This designation will help ensure patients in rural communities maintain access to essential emergency and outpatient services.

health or well-being. One potential way to build a culture of health in a community is for payers and hospitals to work together to set up systems by which patients can earn "care credits" through volunteer work or investments in their health.

Additionally, uninsured or underinsured patients will receive support and information from the care navigator to help them access all available financial resources to support clinical care and promote overall health.

Patients will receive education about how best to navigate the health care system and access covered care using appropriate channels. In the process, they will increase their health literacy and, in turn, be able to assist family members and other community members with how best to access care without overusing resources.

Considerations

This proposed solution reframes both health and health care as essential and encourages cooperation among all payers in a market. Such a solution could help further resources/support for individual and community health. The overarching goal is to increase perception of good health, community involvement and access to quality care as attainable and worthy goals.

Because this solution creates a new framework for payer-hospital-community involvement, designing and implementing it will be a complicated endeavor. Below are a set of considerations when designing this framework:

Financial obligations among multiple organizations will require unprecedented coordination and transparency. Cultural changes will be required by all parties, including payers, hospitals and patients. These cultural changes will need to be sustained long-term for the public-private partnership to remain viable.

- Clear expectations must be articulated among all parties at all times. Expect some challenges as organizations work to adapt to new ways of doing things.
- Strong, innovative leadership at the highest levels will be essential to achieve success. Bold initiatives like a public-private funding pool may require at least one high-profile, effective champion to lead change and convince others to follow suit.
- Location-agnostic care must be allowed for public-private partnerships to succeed. This will also require a shift in thinking among both payers and hospitals from competition to cooperation.
- Extensive resources must be available for community education to help low-health literacy community members see the value in emphasizing healthy behaviors and preventive care.
- Concerns about low volumes for some core services could still prove challenging.
- Working with multiple funders and service lines could introduce more scrutiny — including state and federal regulations — similar to the attention given to mergers and acquisitions.

Despite the challenges, public-private funding for core services will increase access to essential health care services for rural populations.

Flexible Funding Programs to Support Rural Hospital Infrastructure Transformation

Background

Securing funding for large infrastructure projects is a major challenge for rural hospitals. Moreover, health

care delivery is changing rapidly because advances in technology have enabled some types of care to shift from the hospital to ambulatory settings and into the home. Hospital facilities often are not designed and equipped to support these changes in care delivery.

Rural hospitals also face a sustainability problem: typically, they do not have enough patient volume to support the same health care economics that benefit more densely populated areas, and their payer mix is skewed toward payers that do not cover the full cost of care. In 2017, AHA annual survey data showed that Medicare and Medicaid made up 56% of rural hospitals' net revenue. Overall, hospitals receive 87 cents for every dollar spent caring for Medicare and Medicaid patients.[19]

Accessing capital has become increasingly difficult for rural hospitals that lack the financial margins to support capital investment, leading to continued deterioration of hospital infrastructure. Existing opportunities to secure funding often depend on strong bond ratings, which is hard to come by for rural hospitals.

Common funding sources for rural hospitals include bonds, federal loan grants, corporate capital allocations, local, county and state funding, Community Development Financial Institutions (CDFIs)[20] and self-funding. While these funding sources provide some support, the spectrum of current funding mechanisms cannot adequately meet the needs for rural hospitals.

Solutions

The Task Force recommends prioritizing infrastructure development using a "now-near-far" framework that originated with Jim Hackett, CEO of Steelcase and later Ford Motor Co.[21]

- **Now:** Be successful in the "now" while also making the critical pivot to the "far"
- **Near:** Place bets on the future and allocate resources to support those bets
- **Far:** Envision a future state, knowing that any prediction is uncertain and subject to change

Specifically, the Task Force recommends using the "now" and the "near" to invest in rural infrastructure using existing funding streams such as grants and innovative strategies such as contingent payment programs (an example of which is described in the next section) and forming regional collaboratives. Looking to the "far," the recommendation involves designing a rural infrastructure funding program that is tied to clinical transformation and reimagines the way health care is delivered in rural communities. The group envisions a "Hill-Burton 2.0," in the hopes that it can have the same transformative impact on rural infrastructure that the original Hill-Burton program did nationally.[22]

Below is the Task Force application of the Now, Near, Far framework to making rural infrastructure investments:

Now (1-2 years): Using Existing Resources

Use non-traditional funding structures where agreements between hospitals and private companies such as engineering/construction organizations are contingent on mutually agreed upon results and shifts the risk to the company. This provides hospitals the opportunity to spread out infrastructure costs over a manageable period of time. An agreement between Cornell College in Iowa and Johnson Controls offers an example of how this model might work: the company provided financing to the school for improvements to building systems, and the college's installment payments on the loan were contingent on achieving mutually agreed-upon goals for the project — an arrangement which placed the company at financial risk if the goals were not achieved and made it a partner in the project rather than merely a contractor.[23]

Raise awareness and further utilize/expand resources such as:

- **Community Development Financial Institutions (CDFIs).** These are public-private-philanthropic

funding options, partially supported by the U.S. Treasury,[24] that offer financing and development services to rural communities and build credibility to make rural borrowers more attractive to other investors. CDFIs strategically provide loans for a range of projects, often infrastructure, and can partner with other funders to strengthen the capacity of a local endeavor.[25]

- **National Telehealth Resource Centers.** (See Telemedicine section)
- **Initiatives** through agencies such as the Federal Communications Commission and the U.S. Department of Agriculture to expand rural broadband access.
- **Philanthropic Opportunities.** (See Philanthropy section)

Regulatory/Legislative Initiatives

AHA is working to pass a bill H.R. 3967 Municipal Bond Market Support Act of 2019 to make it easier for small, community banks to help their local hospital through tax-exempt financing.[26]

Near (2-5 years): Regional Collaboratives

Regionally focused care delivery partnerships offer several benefits. Providers develop greater expertise as they treat a higher number of patients within a given specialty. Partnerships can also mitigate the challenges associated with supply and demand of health care providers in rural communities. Such partnerships have the potential to improve quality outcomes by reducing duplication of services and decreasing competition across hospitals and health systems.[27]

Regional collaboratives could expand beyond the clinical realm to include administrative benefits such as, consolidated purchasing power for supplies and services and working together on large capital investments such as information technology/telecommunications infrastructure. (See Strategic Partnerships section for more about collaborations.)

These collaborations could include:

- Contractual collaborations, such as referral and co-location arrangements or an agreement for the purchase of clinical and/or administrative services
- Formation of a consortium or network that allows for sharing of clinical and administrative functions, as well as facilitate the continuum of care

Possible strategic areas for collaboration could include:

- Allowing each entity to dedicate its resources to a different set of services, focusing on what it does best, eliminating duplication in services and allowing a community to use its limited resources more efficiently.
- Developing virtual care models with an integrated primary care infrastructure
- Upgrading technology for telehealth and remote/virtual services
- Sharing access to patient care records
- Creating quality improvement programs that operate across primary care, behavioral health and oral health, as well as secondary and tertiary care.
- Sharing administrative and management and medical leadership functions, consolidating capacity or combining efforts to apply for grants that could increase financial support for personnel, equipment or facilities.

Regulatory/Legislative Initiatives

Recently announced revisions to Stark Law and Anti-Kickback Statute that promote care coordination activities would be advantageous to these collaborations/regional arrangements.[28]

Far (5+ years): Location Agnostic Care

Rural health care has an unprecedented opportunity to tie infrastructure modernization to a clinical transformation agenda. Clinical transformation involves assessing and continually improving the way patient care is delivered at all levels in a care delivery organization. It occurs when an organization rejects existing practice patterns that deliver inefficient or less effective results and embraces a common goal of patient safety, clinical outcomes and quality care through process redesign and IT implementation. By effectively blending people, processes and technology, clinical transformation occurs across facilities, departments and clinical fields of expertise and engenders the ability to deliver appropriate care regardless of location.

One example is the Rural Home Hospital Program,[29] a collaboration between the University of Utah and Ariadne Labs, an innovation center run by Brigham and Women's Hospital and Harvard T.H. Chan School of Public Health. The program relies on specially trained local paramedics who travel to the patient's home, supervised via videoconference by a hospital-based physician. Such programs can avert crises among the chronically ill and address acute illnesses without transporting the patient long distances to the hospital — keeping scarce beds for patients who can't be successfully treated any other way.

Another approach, originally developed overseas and deployed in the Mississippi delta, prioritizes preventive care and creates "care pods" to help equalize access to all services between rural and urban settings. Each pod connects facilities and public health offices in smaller towns and rural areas with facilities in larger cities. A network of "health houses" and community health workers is the backbone of the system.[30] The smallest towns have an emergency medical service and a public health office. Larger towns have a nurse practitioner. Small cities have primary care clinics, and hospital care is available in large cities. Under this model, prevention becomes the first mission of the system, reducing the need for care to address specific health problems and easing pressure on clinics and hospitals.

Regulatory/Legislative Initiatives

Regulatory and legislative barriers to interstate licensing, modified during the Covid-19 pandemic, should be permanently removed to allow clinicians to practice across state lines, and reimbursement policies should be permanently adjusted to achieve parity for telehealth.

Congress should consider adopting policies to increase hospital access to capital in vulnerable communities, including grants, tax credits, credit enhancement programs to support enhanced access to loans and innovative public-private partnerships.

Considerations

The use of telehealth technology has grown in recent years as health care providers expand patients' access to remote providers and enhance access to services. Establishing telehealth capacity, however, requires investments in significant start-up costs for videoconferencing equipment, reliable connectivity to other providers and patients, staff training and other resources to manage and maintain services. Rural capital investments, grants and subsidies will also ensure wider patient access to telehealth services for specialty care.[31]

Create a Rural Design Center within CMMI

Background

CMMI was established in 2010 by the Patient Protection and Affordable Care Act to test innovative payment and delivery models that improve or maintain the quality of care provided in Medicare, Medicaid and the Children's Health Insurance Program (CHIP), while also decreasing cost of care. Models are designed to be temporary, lasting less than five years in the experimental phase. These experimental models are identified, developed and tested with the goal of expanding successful practices into permanent programs.

CMMI models are often not designed in a way that allows broad rural participation. Evaluation criteria for potential models do not specifically address rural settings.[32] Large swaths of the country are unable to participate in care transformation models because they do not meet the minimum number of patients required to participate or because their financial situation does not allow them to

The CHART Model

In August 2020, CMMI released a new payment model for rural hospitals that would provide increased financial stability through predictable upfront payments, as well as increased flexibility with respect to rules governing care delivery.

The Community Health Access and Rural Transformation (CHART) Model[33] is an example of the type of model that the proposed Rural Design Center might develop, participate in developing, or offer input on. The CHART model includes the following two tracks:

Community Transformation Track

CMS will select up to 15 Lead Organizations (for example, state Medicaid agencies or Offices of Rural Health, local public health departments, independent practice associations or academic medical centers) that represent a rural community.

- Each organization will work with hospitals and other key entities in the community to implement new care models.
- Each organization will receive up to $5 million in funding.
- Participating hospitals will receive a prospectively set annual payment that will provide a stable revenue stream and create incentives to reduce both fixed costs and avoidable utilization.
- Models will receive operational and regulatory flexibility as needed to test new models, including waivers of certain Medicare requirements, expansion of telehealth, and the ability to offer patients incentives for participating in chronic disease management programs.

Accountable Care Organization (ACO) Transformation Track

CMS will select up to 20 rural-focused ACOs to receive advanced payments as part of joining the Medicare Shared Savings Program.

- A CHART ACO will be able to receive a one-time upfront payment equal to a minimum of $200,000 plus $36 per beneficiary to participate in the 5-year agreement period in the Shared Savings Program.
- A CHART ACO will be able to receive a prospective per beneficiary per month (PBPM) payment equal to a minimum of $8 for up to 24 months.

take on any more risk, even on an experimental basis. Rural hospitals may also not have sufficient staff to comply with reporting requirements intended for larger and better financed institutions in more densely populated areas.

Solution

The Task Force recommends establishing a Rural Design Center, a new division within CMMI that would fall under the category of "Initiatives to Accelerate the Development and Testing of New Payment and Service Delivery Models." With criteria and requirements adjusted for the needs and reality of rural health care, this special designation would allow rural-specific models to be developed, tested, improved and scaled. The Rural Design Center would also consult with internal CMMI model teams to create separate tracks/options within new or existing models that are specifically tailored to meet the needs of rural hospitals and communities.

The Rural Design Center would focus on smaller-scale initiatives that meet the needs of individual communities and encourage participation of rural hospitals and facility

types (federally qualified health centers, critical access hospitals, Medicare-dependent small rural hospitals, etc.) that represent the diversity of communities. With participation requirements that don't rely on patient volume or other measures that tend to exclude rural providers, these small-scale models would provide rural hospitals an opportunity to innovate on the local level without incurring significant risk.

The Rural Design Center would help develop and increase the number of new rural-focused CMMI demonstrations while also expanding successful existing rural demonstrations such as the ACO Investment Model (AIM) to more regions and successful state initiatives to all regions.

To advise this initiative, The Task Force proposes establishing a cadre of rural stakeholders and experts for the CMMI Rural Design Center as a first step toward this solution. With representation from payers, technology consultants, retail pharmacy, funders, academics, and of course providers and hospital CEOs working in rural areas, this group would help design and adapt projects to increase participation and applicability to rural hospitals and other rural health care providers.

Considerations

Since CMMI has the authority to create a new division with the agency, it could establish the proposed Rural Design Center by allocating appropriate funds without legislative action. Ideas coming out of the center would by definition be designed to yield savings to CMS.

Currently, CMMI's models are developed in conjunction with stakeholders, clinical and analytical experts and relevant federal agency representatives. The Rural Design Center's cadre of rural hospital stakeholders and experts would give CMMI access to a greatly expanded rural-specific input to improve its ability to develop new models that address the unique needs of rural providers and patient populations. These stakeholders and experts would also provide a rural perspective to ensure new model ideas align with rural considerations.

For example, one of the criteria, diversity (including demographic, clinical and geographic diversity), has significantly different implications for rural populations than for general populations. This team of experts would help CMMI fully capture the diverse needs of rural hospitals across the country when developing new models.

The Task Force proposes two preliminary models for CMMI to pilot/test through the Rural Design Center:

- Public-Private Funding Pool for Core Services (one of the proposed solutions)
- Promising practices identified in the section on Maternal Health.

Grant-Writing Gig Economy

Background

Government agencies, non-profit organizations and philanthropic groups stand ready to help health care organizations address financial challenges of rural health care delivery. But accessing these funds requires applying for grants. That process takes time, resources, and skills that can be difficult to come by, especially for rural providers who are already stretched thin.

From researching potential opportunities to securing and maintaining a grant, the grant process requires significant time and resources. Rural hospitals often do not have the resources to hire a full-time grant writer and may have limited access to people with the necessary skillset. Grant writing often falls to existing staff who already have a full plate of responsibilities. As a result, rural hospitals may forgo opportunities to apply for funding. Many grant

writers work on a freelance or contract basis, but rural hospitals may not know where to start to find a qualified grant writer.

Successful grant-funded projects require a combination of a well-written and researched proposal matched with a funding source that aligns with the needs of the organization. Grant availability depends on a multitude of factors including, but not limited to, geographic location, priority issue, capital resources and need and impact in the community. Minor errors in the grant-writing process can leave a rural hospital without a grant and waste already constrained resources. Grant money usually comes with tight restrictions on funds and strict reporting requirements that add extra work to project management — constraints that experienced grant writers can recognize and work with but catch some organizations off guard.

Solution

Apps like Uber, InstaCart and DoorDash match the needs of consumers with people willing and able to fill those needs. Applying a similar approach to grant writing can help connect hospitals and rural health care providers with qualified professionals who have the skills and experience to write grants that secure funding for needed services and programs.

The AHA intends to create an online platform and corresponding app that helps connect hospitals to qualified grant writers who will work on a contract or per-project basis. Supporting and encouraging a gig-economy approach can help rural hospitals submit applications for grants or participate in demonstration projects sponsored by the Centers for Medicare and Medicaid Services' Innovation Center and other funders. This service will allow for a sliding fee scale with pre-negotiated rates or a fixed amount of time/dollars to ensure equitable access for small, rural and other low-resource hospitals. Grant writers would agree to the fee structure in exchange for connections to potential clients. The app would be developed by AHA and publicized to member hospitals.

Many small and rural hospitals lack the existing strategic relationships with grant program officers that larger systems with more resources often benefit from. Large or non-local funders may also have misconceptions about rural communities that affect the likelihood of understanding and funding rural hospitals. A professional grant writer can help paint a more accurate picture of rural health care challenges, fill in gaps in understanding and create new connections based on their area of expertise and contacts, opening the door for new opportunities. In addition, a contracted grant writer will have dedicated time to devote to the project and ensure complex regulatory requirements are met. They may also have additional knowledge of program evaluation, including specific measures to use in reporting outcomes that help ensure grant success.[34]

Grant Writing Process

The grant writer handles all stages of the grant writing process:

1. Conduct preliminary proposal research to identify needs and focus, find prospective grants and develop a general proposal and budget.
2. Once a funding source is identified, tailor a detailed proposal to the funder's specifications and align the narrative with the organization's needs and goals.
3. Submit proposal and monitor progress to ensure all application requirements are satisfied.

Once the service is established, possible enhancements might include programs by which larger, better-resourced hospitals share or loan their grant writing staff members to smaller hospitals as well as alliances to provide training to build the pool of qualified grant writers.

Considerations

The online platform will create a "runway" for small/rural hospitals to pursue innovation in care delivery with new and expanded financial resources that may be out of reach today. Successful grant application and implementation will allow small and rural hospitals to secure funding resulting in significant improvements for the hospital and community it serves.

This offering may require some oversight and funding from AHA or an association of grant writers to ensure the program meets the needs and expectations of participating hospitals and writer/contractors. Connecting participants with educational resources for rural hospital administrators to learn more about the grants process and for grant writers to learn more about rural health care might help accomplish this goal.

PROMISING PRACTICES

Global Budget Payment Model

Background

Policymakers increasingly recognize that the current health care ecosystem, in which health care expenditures consume an ever-growing percentage of the nation's gross domestic product (GDP), is not sustainable.[35] However, the most widely used policy levers to address skyrocketing health spending — reducing benefits, lowering provider payments and curtailing program eligibility — have failed to rein in health care costs.

Some policy experts explain these failures by noting that we must incentivize different behaviors among all parts of the system to achieve meaningful and sustainable health care spending reductions. Payment policy reform is often called out as a necessary next step to bend the spending curve in American health care. Support from Republican and Democratic administrations has accelerated the shift from the existing fee-for-service (volume-based) payment model to a variety of "pay-for-value" programs.

To date, hospital and health system leaders have shown a range of responses to these "pay-for-value" payment arrangements. Some have been willing to enter into value-based payment arrangements for a subset of their patient populations, while others remain enmeshed in the fee-for-service model.

The Task Force believes that expanding population-based payments is a viable cost-containment strategy that should be encouraged for broader adoption, including among rural institutions. Population-based payments take many forms, including pre-payment, partial capitation, capitation models and bundled payments, among others. These models create distinct advantages for hospitals, offering flexible access to resources while providing incentives for early intervention and innovative thinking to improve outcomes while keeping costs down.

The basic framework is that health care providers receive a set, risk-adjusted payment for each plan enrollee during a defined period of time. Payers make their contractual payments to providers regardless of whether the enrollee receives care during that period.

The common element in these payment models is their potential to offer budget predictability and cash flow stability to hospitals, while encouraging quality gains in preventive health and other outcomes. This financial stability is likely to be viewed favorably by rural hospitals, where inconsistent patient volumes can wreak havoc with fee-for-service-based budgets.

One promising solution to help rural health care leaders overcome their wariness of value-based payment is to adopt a global budget payment model.

Overview

The global budget payment model is a population-based, value-oriented model that shifts reimbursement for health care services away from volume-based payments to a single payment that encompasses certain costs associated with caring for a population. Payers compensate participating hospitals with a fixed amount set in advance — to cover all inpatient and hospital-based outpatient items and services. Hospitals then use those funds as needed to provide that care.

In their most basic form, global budget payments provide a fixed amount of reimbursement for a fixed period of time for a specified population — rather than fixed rates for individual services or cases. Therefore, if a provider's costs are less than the budget, they retain the difference; if a provider's costs exceed the budget, the provider must absorb the difference.

The global budget payment model is not intrinsically tailored to any particular care setting — urban or rural. But rural communities may be well-situated to take advantage

of the model's advantages while avoiding its potential disadvantages. To test this model, the CMS Innovation Center partnered with the State of Pennsylvania to create the country's first large-scale rural global budget payment program, the Pennsylvania Rural Health Model.

Pennsylvania Rural Health Model

The Pennsylvania Department of Health administers the Pennsylvania Rural Health Model (PARHM) jointly with CMS.[36] Its goal is ambitious: To combine the use of hospital global budgets with care delivery transformation efforts. PARHM seeks to improve care access and quality for rural Pennsylvanians while increasing participating hospitals' financial viability and reducing the growth of hospital expenditures across all payers, including Medicare. Knowing how difficult it is for rural hospitals to innovate given their many financial uncertainties, PARHM is designed to test whether the financial stability global budgets offer will encourage participating rural hospitals to explore the care innovations best suited to their local communities.

To that end, PARHM features two key components:

- **Hospital Global Budgets.** Pennsylvania prospectively sets the all-payer global budget for each participating rural hospital. Budgets are based on the hospital's historical net revenue for inpatient and outpatient hospital-based services from all participating payers. Each participating payer pays each participating hospital for all inpatient and outpatient hospital-based services based on the payer's respective portion of this global budget. CMS retains review and approval privileges for the Medicare fee-for-service (FFS) portion of the global budgets that Pennsylvania proposes for each participant. CMS also reviews and approves the State's methodology for calculating the global budgets are subject to CMS review and approval.
- **Hospital Care Delivery Transformation.** Participating hospitals must also refine and redesign their care offerings as outlined in their annual Rural Hospital Transformation Plan. Each hospital must show how it intends to get continuous feedback from stakeholders in the community and tailor its services to the needs of their local community. Specifically, each hospital must describe how it intends to improve quality, increase access to preventive care and generate savings to the Medicare program. The state provides rural hospitals with technical assistance as needed in preparing Rural Hospital Transformation Plans each year. The State of Pennsylvania and CMS must approve each participating hospital's Rural Hospital Transformation Plan.

PARHM participation is open to both critical access hospitals and acute care hospitals throughout rural Pennsylvania. The 13 hospitals that currently participate represent a mixture of both types of hospitals and cover a broad swath of the state.

Pennsylvania has contracted with a broad range of payers, including Medicare, Medicaid and a variety of commercial plans. PARHM is funded through 2024 and consists of seven performance years, including one pre-implementation planning year in 2017-2018.

Vermont & Maryland All-Payer ACOs

To date, Pennsylvania is the only state whose global budget payment model focuses exclusively on rural hospitals, but CMS has explored global budget payments in two other states, Maryland and Vermont.

CMS partnered with the State of Maryland in 2014 to launch the Maryland All-Payer Model.[37] This program established global budgets — an annualized fixed amount of revenue to cover an entire year — for participating hospitals to reduce Medicare hospital expenditures while improving care for beneficiaries. CMS and the State of Maryland decided to pilot this project with rural hospitals because they might have a greater incentive to work through any difficulties compared with their urban

counterparts, who could simply refer patients to nearby competitors as needed. Although this program created significant savings for Medicare, its focus on the inpatient setting limited its future successes.

Its successor, the Maryland Total Cost of Care (TCOC) Model, includes three programs:[38]

- **Hospital Payment Program.** In this demonstration of population-based payments, each hospital receives a payment amount to cover all hospital services provided during the year. This approach creates a financial incentive for hospitals to reduce unnecessary hospitalizations, including readmissions.
- **Care Redesign Program.** Hospitals that have saved a predetermined sum may make incentive payments to non-hospital health care providers who develop quality-improvement offerings. The effect is neutral to overall Medicare expenditures because the incentive payments cannot exceed the amount saved.
- **Maryland Primary Care Program.** Participating primary care practices receive an additional monthly payment from CMS to cover care management. The program includes a performance-based incentive payment to providers who reduce their Medicare hospitalization rate.

Pennsylvania Rural Health Model (PARHM)

As part of the Pennsylvania Rural Health Model (PARHM), the State of Pennsylvania has set three key goals related to population health outcomes and access. Participating hospitals must meet these goals each year:

- Increased access to primary and specialty services
- Reduced rural health disparities due to improved chronic disease management and preventive screenings
- Decreased substance use disorder-related deaths, along with improved access to treatment for opioid misuse

PAHRM purposefully applies equal weight to both financial and quality improvement goals.

Since 2017, CMS has offered the Vermont All-Payer Accountable Care Organization (ACO) Model.[39] The initiative includes a Medicare ACO model tailored to the state, as well as Medicaid and all private payers. CMS provided Vermont up to $9.5 million in start-up investment to providers to cover care coordination and fund collaborations with community-based providers. The Vermont All-Payer ACO Model builds on the Maryland All-Payer Model by bringing statewide health care transformation beyond the hospital.

Considerations

The Task Force emphasizes that global payments should be made at a predictable, stable and sufficient level to allow providers to build the infrastructure and capability to redesign care delivery.

Additionally, successful global budget payment models should have these traits:[40]

- **Broad Provider Participation.** Participation may be limited to hospitals or could be expanded to include additional health care providers (e.g., physicians). The broader the participation, the more alignment between health care providers and accountability for the health care services offered within a community.
- **Mix of Public and Private Payers.** Participation by all commercial and government-funded health plans affords hospitals the most opportunity to focus their efforts on success, rather than attempting to simultaneously operate under fee-for-service and global budget payment models. However, this could be the most difficult factor to achieve.
- **Appropriate Quality Measures.** In order to ensure quality oversight, standardized metrics must be established to capture the quality of care, population health outcomes and patient experience.[41] These metrics should be implemented by setting pre-defined benchmarks or by rewarding hospitals that continuously improve over time. Global budget payment models should also include ways to track and measure the success of the program, such

as the financial viability of the health system and reductions in preventable inpatient admissions.

Additionally, global budget payment models should be adaptable to the specific needs and culture of each participating institution, with acknowledgement that hospitals may be in various stages of adoption or moving away from fee-for-service.

CMS acknowledges that rural providers have generally had lower rates of participation in alternative payment models, so customization is key, as is the ability to partner with compatible organizations. For example, partnering across regions to build out telehealth platforms is very effective.

Flexibility in global budget program design can have an unexpected benefit of providing operational stability during unexpected challenges. For example, the Task Force learned that PARHM's capitated payments provided a financial buffer against the reduction in services provided during the COVID-19 pandemic. They have not experienced the same pandemic-related cash-flow problems compared to their counterparts not operating in a global budget payment environment.

The Task Force recommends that any new global budget models include a capital infrastructure component in order to ensure hospitals have the necessary resources to provide appropriate patient care services. Capital improvements also allow health care institutions opportunities to customize their care offerings to respond to their communities' specific needs. One weakness of the otherwise successful Pennsylvania Rural Health Model is that it does not currently fund any infrastructure improvements.

A further limitation is that global budget payment programs are challenging to set up due to their technical requirements. Rural hospitals could not reasonably expect to create this model on their own because of the technical skills needed to create the methodology.

More needs to be understood about global budget payments, but payment policies that offer more predictable, stable funding that lets providers focus on providing the right care to the right patient at the right time seems directionally correct. The Task Force believes global budgets offer a promising path forward for overhauling our costly health care delivery system to rein in costs while improving care.

Rural Hospital Federal Tax Credit Program

Background

Most rural hospitals operate on the edge of financial sustainability. Profit margins — already thinner than urban hospitals — declined from 2011 to 2017, the same time period in which many urban hospitals improved their financial position.[42] Small hospitals (fewer than 25 beds) appear to be the most vulnerable, especially if they are not critical access hospitals and do not receive the extra reimbursement from Medicare.

Since 2010, more than 134 rural hospitals have closed. States with the most rural hospital closures are Texas, Tennessee and North Carolina. The National Rural Health Association estimates that one third of rural hospitals are at risk for closure.[43]

Those closures can have a devastating effect on the communities they serve. Sixty million rural residents across the nation rely on their local hospitals not only for health care but also for jobs, community investment and leadership.[44] According to a working paper published by the National Bureau of Economic Research, rural hospital closures are associated with a 5.9% increase in mortality rates. Death from sepsis increased by 9% when rural hospitals closed, the report found.[45] The COVID-19 pandemic demonstrated the precarious financial situation of many hospitals and the critical importance of accessible, quality care close to home.

Many nonprofit hospitals depend on donations and philanthropy to shrink the gap between operating costs and reimbursement rates, especially in rural areas. Rural residents and local businesses have traditionally stepped up to donate to community hospitals. However, an unintended consequence of the 2017 Tax Cut and Jobs Act[46] was to reduce tax incentives for those contributions. With the increase in the standard deduction for most families, fewer households were eligible for a tax deduction for charitable giving. While nonprofits did not see the hit that some predicted, individual giving did

not rise as expected in 2018 and 2019, a 2020 report to Congress found.[47] The effects of the tax change may be felt more keenly in rural areas, where incomes are lower and less likely to benefit from itemizing their tax deductions (versus taking the standard deduction).

Overview

In 2016, Georgia passed the Rural Hospital Tax Credit Program, which took effect on January 1, 2017. Under the law, individuals and corporations can receive a credit on their state income tax for donations to eligible rural hospitals and health care organizations. Georgia is the only state in the nation that has tried this approach to raising funds for rural hospitals, and it shows promise that could be replicated and improved on a national basis.

The main features of the program are as follows:

- Individuals are eligible for tax credits of $5000 per individual/$10,000 for married filing jointly. (Tax credits cannot exceed donor's tax liability.)
- Corporations can receive tax credits up to 100% of contribution or 75% of state income tax liability.
- Rural hospitals chosen for the program can receive up to $4 million in donations per year, with donations subject to approval and/or a cap during the second half of the calendar year.
- Donors must apply for the tax credit and be approved by the Department of Revenue.
- If the donor does not designate a hospital to receive the funds, or if the hospital designated has already reached the donation cap, funds are distributed to other eligible rural hospitals.

An evaluation of the program by the Georgia Southern University found that Georgia's Rural Hospital Tax Credit program provided needed funds to support rural hospital operating costs, debt reduction, infrastructure and service expansion. However, the evaluation also found room for improvement in the program.[48]

During the first year of the program, donations quickly exceeded the $60 million tax credit cap. However, after the new federal tax law reduced financial incentives for charitable donations, program participation fell off. According to a review of the program by the Georgia Department of Audits and Accounts Performance Audit Division, donations did not always go to the hospitals with the greatest financial need.[49]

The Task Force believes that expanding this tax credit program nationally with a federal tax credit can provide essential funds to support to rural hospitals in all states, including those without state income taxes. (Texas and Tennessee, two of the states with the highest rates of hospital closures,[50] do not have state income taxes.) It can also address some of the weaknesses of the Georgia program and distribute the funds more equitably.

The Task Force believes that the Georgia model holds great potential to encourage charitable giving to rural hospitals as one strategy to help ensure local access to health care in rural communities.

Considerations

While hospital CEOs in rural Georgia feel the tax credit program is helpful and has great potential, they also pointed out some challenges associated with the program that the Task Force believes should be addressed in a federalized version. As noted above, the Georgia program experienced a drop-off in donations after the new federal tax law made it more difficult to claim federal tax deduction in addition to the state tax credit. A state tax credit has limited appeal, especially in states with no income tax. Expanding the model nationally and applying a federal tax credit would greatly increase the appeal and therefore the impact of the program.

The Task Force also recognized the challenges of raising money in economically distressed areas. Many people living in rural areas have low incomes. The complexity of the Georgia program, including the different caps

and the need to apply for the credit and make donation within a specific amount of time, may have hampered its effectiveness and community participation. Changes to the Georgia program after the first year — even ones that improved the program — may have further confused potential donors.[51] However, the idea of attracting community members to invest even in a small way in their local hospital increases their personal stake in rural health care providers and in the health of their communities. Developing effective ways to publicize the program to local residents and businesses and make it accessible and appealing to people who can only donate a small amount may have benefits far beyond the monetary value of the donation.

Another weakness in the Georgia program was the finding that funds were not prioritized for maximum impact and hospitals most at-risk for closure. To ensure that funds go to the hospitals and communities in greatest needs, eligibility requirements for hospital participation must be carefully designed and targeted.

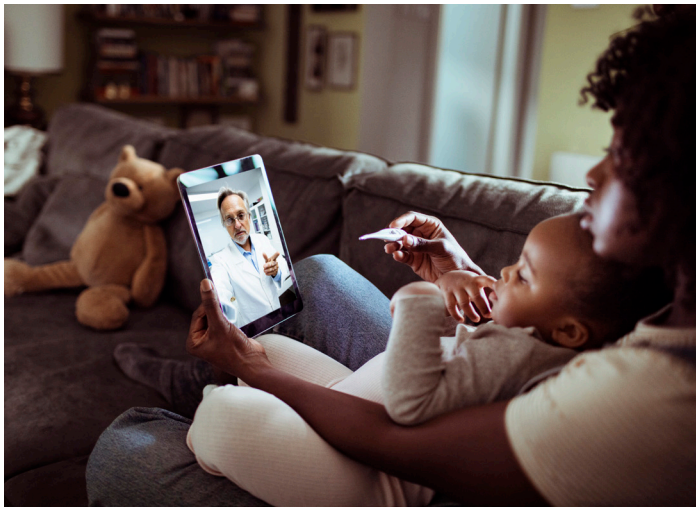
The Task Force believes that these challenges can be overcome with a thoughtfully designed and implemented federal tax credit program that supports and strengthens rural hospitals and helps improve the health of America's rural residents.

Telemedicine

Background

Telemedicine (or telehealth) — health care provided remotely using telecommunications networks — has grown rapidly in the past decade, along with the spread of broadband networks. AHA surveys show that three out of four health systems had telehealth capabilities by 2017, up from one in three in 2010.[52]

Those capabilities went largely underutilized until COVID-19 rapidly transformed telemedicine to a core service for many health systems and providers. Telemedicine has been key both for disseminating effective COVID-19 treatments[53] and maintaining routine health care services without in-person office visits.[54] At NYU Langone Medical Center in New York City, urgent care tele-visits grew six-fold between the beginning of



March and the middle of April 2020. Over that same period, telemedicine came to account for 70% of non-urgent visits for the health system, up from a negligible amount prior to the pandemic.[55] The NYU example is far from isolated. FAIR Health, an independent nonprofit that collects health insurance claims data, shows an astonishing 30-fold increase in telemedicine claims between August 2019 and August 2020.[56]

The abruptly accelerated adoption of telemedicine has highlighted both the benefits and the obstacles connected with effective deployment. The continuing need to provide care in a context of COVID-19 infection control has motivated all parties — providers, payers, and regulators — to find ways to remove those obstacles.

Telemedicine and Rural Health

Rural health care can benefit profoundly from a robust national commitment to telemedicine. Prior to COVID-19, telemedicine had been regarded as especially critical for rural areas.[57] The advantage for these areas is clear: access to a broad range of clinical services without the need to travel long distances.

Specialists often travel to rural areas only few times a month to see patients, which limits opportunities for face-to-face contact. Rural areas also lack certain key essential services, including mental health and substance use services. In 94% of the 734 counties classified as "entirely rural," there are no licensed psychologists.[58] Telemedicine solves both problems by allowing patients to schedule virtual appointments with clinicians in other areas during their regular office hours.

Telemedicine can lower overall costs for rural emergency department patients by thousands of dollars according to a 2017 University of Iowa study.[59] The telemedicine program at Avera McKennan Hospital in Sioux Falls, S.D., showed a net savings of more than $4,000 every time a patient could receive needed emergency care without being transferred to another location, including reduced expenses related to transportation, missed time at work, and costs for family members who accompany patients.

Telehealth can take a variety of forms:[60]

- Patient/provider video or teleconference in real time
- Remote patient monitoring (RPM)
- Store and forward transmission of medical information such as medical records and images
- Mobile health communication (mHealth) using patient cellphones for text, audio and video communication, health reminders, and health-promoting apps

More than two dozen state and regional telehealth networks are currently active in the U.S.[61] Growth has been steady and significant as telecommunications and related technologies have improved: Telemedicine use among Medicare beneficiaries in the rural United States increased by about 28% annually between 2004 and 2013.[62] COVID-19 has only accelerated that expansion.

Barriers to Telemedicine

The growth in telemedicine and telehealth has occurred despite numerous impediments: legal, financial, technical, clinical, and administrative. As with many aspects of the health care system, laws and regulations governing telehealth are state-based and inconsistent from state to state.[63] Overall barriers include:

- **Inadequate Infrastructure.** Rural areas lag more populated areas in broadband capabilities required for video-based telehealth. (See section on broadband for more information on how to strengthen technology infrastructure in rural areas.)
- **Lack of Interstate Licensing.** The service area for a rural telehealth network can span several states. Under current licensure requirements (suspended during the COVID-19 pandemic but not permanently), clinicians must be licensed in all of them individually in order to provide care for a patient regardless of their respective locations.
- **Lack of Reimbursement.** Medicare, Medicaid and commercial insurers do not consistently reimburse telehealth services at rates commensurate with the amount of investment and effort they represent.
- **Problems with Data Flow.** Patients' electronic health records and other pertinent information are not always readily available to clinicians during telehealth visits, due to problems with interoperability or lack of data-sharing arrangements among providers.
- **Not Enough Trained Clinicians.** Delivering services through telehealth requires developing new skills and strategies to engage patients, elicit useful information and perform effective examinations.
- **Lack of Patient Engagement.** Both clinicians and patients have to be comfortable with telehealth encounters.

Overview

Telehealth can play a key role in improving rural health care, and there are significant underutilized resources available to help providers establish and expand these services.

The **National Consortium of Telehealth Resource Centers** (NCTRC)[64] was established in 2017 and grew out of a telehealth grant program funded by the federal Health Resources and Services Administration (HRSA) in the early 2000s. The consortium continues to be funded by the Department of Health and Human Services (HHS) and HRSA and administered through a grant from HRSA's Office for the Advancement of Telehealth. There are 12 regional and two national TRCs that work collaboratively to ensure telehealth programs are up and running in rural and underserved communities, Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs). Staffed by experts in policy, technology and implementation, the regional centers cover all the states and territories of the U.S., and many of their services are provided at no charge. Providers and health systems wishing to establish

or expand telehealth services should take full advantage of the expertise of their regional TRC.

Project ECHO (Extension for Community Healthcare Outcomes),[65] which receives funding from state and federal government agencies as well as other sources, is a collaborative model of medical education and care management that increases access to specialty treatment in rural and underserved areas by providing front-line clinicians with the knowledge and support they need to manage patients with complex conditions. Expert teams, located at "hubs," lead virtual clinics, amplifying the capacity for providers to deliver best-in-practice care to the underserved in their own communities. Project ECHO has supported such diverse efforts as training community health workers to operate as part of care teams, expanding remote consults between primary care providers and endocrinologists to improve diabetes care, and educating health professionals on pain management and opioids.

Administered out of the University of New Mexico School of Medicine, the project currently operates 423 hubs in 44 countries, including 239 in the U.S. that draw on expertise of numerous universities, government agencies, professional societies, and not for profit organizations. Project ECHO recently received $237 million in funding as part of the COVID Aid, Relief and Economic Security (CARES) Act and is one of six finalists for a potential $100 million grant from the MacArthur Foundation[66] to be awarded in 2021. In September, the New Mexico Congressional delegation, joined by 44 other legislators in a bipartisan effort, formally requested that HHS issue guidance on ways that the Medicare and Medicaid programs might be enabled to provide financial support for the programs and services of Project ECHO.[62]

Considerations

As noted above, many stumbling blocks to more effective rural telehealth deployment can be addressed with changes in laws and regulations. COVID-19 has presented a unique opportunity to speed those changes. To encourage the adoption of telehealth during the pandemic, the Centers for Medicare and Medicaid Services made several emergency changes at the direction of Congress:[67]

- Waiving limitations on the types of health care professionals that can furnish telehealth services to include all those that are eligible to bill Medicare for their professional services. This waiver opened telehealth to physical therapists, occupational therapists and speech language pathologists, among others.
- Allowing hospitals to bill for telehealth services as they would for on-site services for Medicare patients registered as outpatients, including the originating site facility fee and therapy, education, and training services (e.g., counseling, psychotherapy, group therapy and partial hospitalization).
- Changing its process during the emergency so that it can add, on a sub-regulatory basis, new services to the list of Medicare services that may be furnished via telehealth.
- Formalizing the Coronavirus Aid, Relief, and Economic Security (CARES) Act provision that authorizes payment for Medicare telehealth services provided by rural health clinics and federally qualified health clinics acting as distant sites.
- Broadening providers' ability to furnish services via audio-only communication and increasing payment for telephone visits to match payments for similar office and outpatient visits.
- Permitting assessments to be performed via audio/video or audio-only telehealth as part of CMS's bundled payment program for opioid treatment plans.

Making these changes permanent, as outlined in AHA's July 2020 telehealth fact sheet,[68] would give rural hospital leaders the opportunity to bolster telehealth and greatly

increase access to "right care, right place, right time" for their far-flung patient populations.

Broadband and Mobile Technology

Background

As noted in the section on telemedicine, rural health care can benefit significantly and uniquely from offering its patients remote access to care. This benefit has been highlighted during the COVID-19 pandemic to meet the demand for health care services while limiting direct contact. The pandemic has led to rapid growth in what might be called "classic" telehealth — patient and clinician connecting in real time via linked computer screens — as it called attention to the potential for mobile phones to act as transformative tools for rural health care, both in real time and asynchronously.

However, both computer-based telehealth and mobile telehealth depend on robust communication networks, an area where rural infrastructure lags significantly.[69] In addition to direct patient care, high-capacity broadband and mobile networks are also essential for health information exchange, other forms of telemedicine (for example, e-consults between providers, tele-radiology, and remote ICU monitoring) and general hospital operations. High-capacity broadband would allow providers to take advantage of cloud-based services for both clinical and general administrative applications and would give them more ready access to remote workers for back-office operations — a key advantage because of shortages of qualified workers in many areas.

The availability of high-capacity broadband is limited in rural areas. Where it exists, it can be very expensive for both individual and organizational users. Federal Communications Commission 2019 data shows that while more than 97% of urban areas had access to 100Mbps broadband networks, their reach in rural areas was only 67% and in tribal lands only 64%. The disparities are even greater for broadband speeds of 250 Mbps: almost 95% of urban areas have at least one provider that offers this capacity, while only 56% of rural areas and 50% of tribal areas have at least one.[70] High-speed LTE mobile networks (10Mbps/3Mbps) showed better penetration — 70% in rural areas and 64% in tribal lands — but they still lagged urban areas (90.5%), according to a 2018 FCC report.[71]

In 2019, the Veterans' Health Administration's Office of Rural Health estimated that 42% of rural veterans enrolled in VA do not have internet access adequate to support their use of VA telehealth and other online services.[72] That is a considerable portion of the population to leave unserved by the potential of this technology.

The FCC recommends that hospitals have access to a minimum of 100Mbps broadband capacity to support functions such as simultaneous use of EHR and high-quality video consultations, real-time image transfer, continuous remote monitoring and consultations using high-definition video. For large academic medical centers, 1,000 Mbps is recommended.[73] For rural hospitals to take advantage of greater telehealth possibilities or forge e-consulting relationships with larger hospitals, they too would presumably need more than the bare minimum broadband capacity.

In addition to broadband, high-speed mobile networks would also benefit health care delivery in rural communities. Rural communities face a real shortage of providers and need ways to stretch the capacity of the ones they have. The asynchronous communications enabled by telehealth allow providers to provide care on a schedule that does not depend on coordination with the patient.

Mobile technology — including texts, video and audio calls and apps — can help providers extend their services to hard-to-reach communities. Improved mobile patient engagement can have a substantial positive impact on population health in rural and small community care settings.

Mobile communication tactics, including texting, can complement telehealth visits by enhancing pre- and post-visit navigation, supporting medication adherence and reinforcing behavior change to improve health outcomes. Texting is particularly fundamental because it doesn't depend on smartphone capabilities and can be used with even the most basic mobile phone, reaching populations that are underserved by health care and technology. Unlike some health innovations that can deepen health

disparities due to the digital divide, texting offers an accessible channel for all populations. Pew Research estimates that 96% of Americans own a cell phone, while 81% of adults own smartphones and 73% have home broadband.[74] Increasing availability of broadband and/or high-speed mobile networks holds the potential to improve health care delivery and health monitoring for a broad swath of the country.

With the implementation of 5G mobile networks, providers will be able to share real-time video/audio feedback, and even "haptic" feedback — fine motor and sensory movements — which can in turn enable procedures to be safely performed remotely with robotic instruments.[75] Such networks can also enable the "Internet of Things," for example, allowing patients to be monitored continuously in their homes in real time with heart rate or blood glucose sensors.

Rural areas must be included in the rollout of this next-generation capability.

Overview

Several states with large rural populations have taken the lead in investing in broadband, using a combination of state and federal funding. In addition to supporting online opportunities for education and business purposes, these infrastructure investments also aim to expand advanced telehealth services to previously unreached areas.

Earlier this year, Virginia allocated more than $18 million to provide "last-mile" broadband connectivity to 12 counties, part of a multi-year initiative to wire up all unserved parts of the state.[76] Governor Ralph Northam called out telemedicine as a key function to be enabled by the investment. Last year, Illinois earmarked $420 million over six years to expand broadband throughout the state as part of its "Rebuild Illinois" infrastructure program.[77]

Before the pandemic, Maine had identified access to broadband services as one of the obstacles to wider use of telehealth among the state's rural residents, many of whom are over 65 and depend on Medicare coverage for health care. In 2019, the state passed a law that requires Medicaid and private insurers to reimburse for telehealth on a par with in-person services.[78] However, lack of broadband access in rural areas — along with limitations on Medicare reimbursement for telemedicine — lessened the impact of the legislation. The state's Congressional representatives have been on the forefront of efforts to address both issues.[79]

In the meantime, some rural communities in Maine have spearheaded their own efforts to bring broadband to their areas. The Maine Broadband Coalition — representing organizations, communities and internet users in the state — is actively advocating and supporting broadband expansion by collecting data on the state's digital divide.[80] In November 2020, the governor announced that $5.6 million in coronavirus relief money will fund the infrastructure needed to expand broadband access in rural Maine.[81] Other states with significant rural populations — including Idaho, Iowa, Missouri, Oregon and Vermont — also earmarked pandemic relief funds to address connectivity issues that affect access to telehealth services.[82]

Some providers already maintain active telehealth networks, and increased capacity will allow them to expand their scope of services, extend their service area and provide more reliable connectivity. Avera Health serves a large rural area across the upper Midwest and operates the single largest telehealth network in the U.S.; Avera eCARE, which provides innovative telemedicine services to more than 300 locations across South Dakota, North Dakota, Minnesota, Iowa and Nebraska. Avera eCARE also provides telehealth services to other health systems, hospitals, long-term care facilities, schools, correctional health facilities and other sites nationally — a total of 400 locations in 18 states. Its activities include collaboration with Indian Health Service (IHS) to provide emergency support, behavioral health and specialty appointments to reservation communities.

Considerations

The need to support the build-out of broadband in rural areas is well understood in regulatory circles, and several funding efforts are in progress, including the $20.4 billion Rural Digital Opportunity Fund, launched by the FCC in early 2020.[83]

Specific to health care, the FCC's Connected Care Pilot Program will provide up to $100 million from the Universal Service Fund (USF) over a three-year period to selected applicants to support the provision of connected care services. The Pilot Program will provide funding for selected pilot projects to cover 85% of the eligible costs of broadband connectivity, network equipment and information services necessary to provide connected care services to the intended patient population. The application period opened November 6, 2020 and closed December 7.[84]

It is essential that rural health care leaders press for continued government support to expand and strengthen broadband/mobile communication networks in rural areas. This will involve engaging both broadband infrastructure companies as well as telecommunications firms. Fortunately, the benefits of this expansion are not unique to health care, and industry leaders can join forces with their colleagues in education and agriculture, as well as with businesses and consumers, to make the case.

All local assets should be identified, and communities should work together to develop a holistic plan that addresses local and regional health and health care in addition to these other essential services.

Health care leaders should talk directly with elected officials and invite them to see firsthand how improved broadband and mobile service can enhance care.

Strategic Partnerships and Affiliations

Background

The COVID-19 pandemic highlighted the critical role rural hospitals play in community health as well as the challenges they face to survive. As the pandemic raged across the country, rural hospitals and their staff stepped up to provide critical care close to home — even as their already significant fiscal challenges increased.

Rural hospitals operate on razor thin margins, often depending on elective procedures and commercially insured patients to make up for shortfalls in reimbursements for uninsured, Medicaid and Medicare patients. This dependence put many facilities at risk in Spring 2020 when the pandemic forced hospitals to cease non-urgent and elective services to focus resources on COVID-19 patients. Early numbers on hospital closures in 2020 showed they were at least on pace with 2019's record rates — and might likely have been higher without relief funds from the CARES Act.[85] To survive, many hospitals forged partnerships or accelerated alliances with larger systems and academic hospitals to provide additional expertise and resources. At an April meeting of the Future of Rural Health Task Force, several members reported that strategic alliances helped their organizations respond more effectively and efficiently to the pandemic. Examples included working with local health boards and providers to ensure proper PPE and resources, consulting with regional tertiary health centers to transfer critically ill patients and increased communications with state, regional and national hospital associations to stay informed on the latest information.

Strategic partnerships and affiliations can benefit both rural and urban health care organizations. Rural organizations are looking for access to technology, staff recruitment, expanded services, group purchasing opportunities and increased access to capital. Urban organizations may be motivated by a desire to increase their referral base, strengthen rural communities or allocate costs more effectively.

Rural hospitals are deeply rooted in their communities, and their local impact goes far beyond the health of local residents. As one of the largest employers in rural communities, hospitals play important roles in communities' economic health. With connections to local social service and other community-based organizations, rural hospitals have opportunities to impact housing, transportation, childcare, education and other services that keep communities vibrant and alive. Rural hospitals, therefore, can give larger hospital systems an entry point

into these communities, resulting in synergies that benefit both entities — and the populations they serve.

In recent years, many rural hospitals have merged or become affiliates of larger hospital systems. These arrangements can take various forms. Possibilities include management agreements (where the larger system takes control of operations without assuming ownership), joint ventures (in which hospitals combine efforts for a particular task), acquisition/lease (in which the larger entity purchases assets or equity ownership or takes a share of distributions) and other models. One of the core drivers of these partnerships is the need to shore up the local facility, including capital and clinical infrastructure, so that when possible, patients can receive care at the local rural hospital rather than transferring to tertiary facilities.

The idea of merging with a larger facility often goes against the grain for fiercely independent rural hospitals. Rural hospitals pride themselves on their personal touch, their knowledge of the local community and the idea of neighbors caring for neighbors. Used to working autonomously, they may associate larger systems with more regulations, oversight and bureaucracy. Increased efficiency and streamlining may mean layoffs or re-assignments of local staff. However, there are ways rural hospitals can extend their reach both inside and beyond their communities to address their goals and challenges, while maintaining as much autonomy as possible.

Overview

Rural hospitals are already connectors in their communities. By building on this role — reaching both inside their own communities and outside to state, regional and national entities — hospitals can optimize the services they offer the community while addressing challenges that affect patient care, more sustainably. Models are evolving for new types of partnerships and affiliations that achieve objectives for both rural and urban organizations and revitalize health care delivery in rural areas. Options exist short of an acquisition, including clinical affiliation or hospital management or telehealth arrangements. For example, hospitals can identify service lines that are lacking in the community and partner with healthcare organizations in a neighboring area to provide that service. Hospitals can take a leadership role in improving transportation options in their communities by getting involved with efforts toward public transportation efforts or providing vouchers for a local taxi services or ride-hailing app.

By looking carefully at the needs of the community and how best to meet those needs now and in the future, rural hospitals can recalibrate the focus of their services and find the most effective and sustainable way to deliver what the community needs. Some of these models include:

Hub and Spoke System. In these partnerships, most intensive medical interventions are provided on a main campus, or hub, with more limited and targeted basic services offered at sites distributed across the region. For example, the Willis-Knighton Medical Center in Shreveport, LA, serves as the hub for a system that includes 8 smaller health systems and three rural health partners to serve most of western Louisiana. These types of arrangements can result in more consistent and efficient quality care for a larger service area while also offering improved responsiveness to market developments or environmental conditions. The availability of telehealth options can expand these models so that centers of excellence can exist far away, and services are ultimately less geographically constrained.

Integrated Structures for Payer Contracts. Through organizations or structures such as Accountable Care Organizations (ACOs) and Clinically Integrated Networks (CINs), smaller organizations can pursue joint contracting with larger organizations leading the way while still maintaining a degree of autonomy.

Joint Venture Affiliations. Affiliating with larger health systems for a specific project can bring resources and

expertise to rural areas and set the stage for further collaboration. These can be arranged around a service line — extending availability of specialty care to rural areas — either as an individual agreement or part of a high-level affiliation, such as a management agreement.

- Service line joint ventures are an example of a moderate integration arrangement: they provide options for co-ownership so that smaller organizations only cede some control, where necessary, for core services that are not readily accessible in rural communities. Relationships forged in service line agreements can then evolve as other needs emerge. For example, Sky Lakes Medical Center in Klamath Falls, OR, turned to Oregon Health and Sciences University — with whom they have partnered on a family medicine residency program since 1992 — for expertise and "family medicine manpower" during the pandemic.[87]

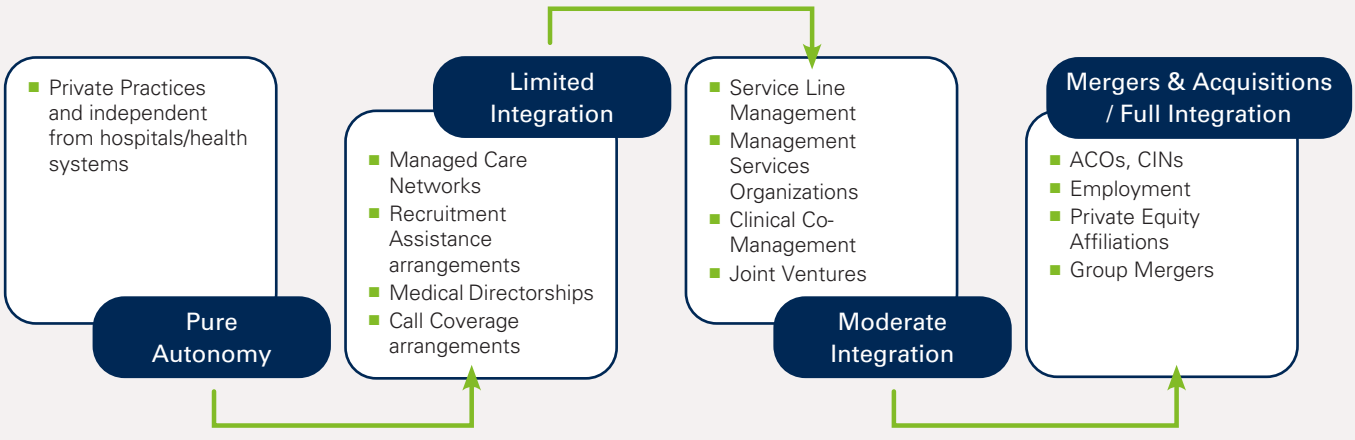
- Management agreements: an example of a full-integration arrangement, these can vary depending on how the governance agreement is structured. For example, the organization can retain full ownership of the facility but tap into the expertise of the large health systems.

Collaboration with public or private entities: These innovations can take many forms. Technology collaborations can use data analytics with other creative strategies to improve patient outcomes and operational efficiency. Technology groups can help build infrastructure and expand capabilities in such key areas as telehealth and secure information exchange. Community organizations, such as YMCAs and housing groups, can help hospitals reach out with preventive screenings, address the social determinants of health and target the specific needs of the community. Joining forces with other smaller facilities can create buying power and economies of scale usually unavailable to independent and isolated hospitals.[88]

Participation in state and national programs: Rural hospitals can build their support networks by actively participating in state and national certification or standardization programs, such as pursuing official recognition as a Patient-Centered Medical Home (PCMH), joining a data sharing agreement on the state level or applying to become a federally qualified health center (FQHC).[89]

Partnering with local organizations: Building and strengthening connections with local community-based organizations can lead to new opportunities to improve the health of local residents and address their overall health needs. Board representation — both hospital leaders serving on community boards and community members serving on hospital boards — is one way to build partnerships.[90] Hospitals can also provide financial or in-kind support to community groups, build volunteer programs and encourage hospital employees to volunteer for other local organizations and churches and develop focus groups to gauge public response to hospital programs. As the Southcentral Foundation in Anchorage, Alaska, has demonstrated through its Nuka System of

Levels of Strategic Affiliation[86]



Care, reaching into the local community can be a powerful way to grow an innovative health care delivery system.[91] Originally part of the Indian Health Service and controlled by a bureaucracy 5000 miles away, Southcentral struggled to serve its patients. In 1999 the Alaskan Native people chose to become customer-owners of the health care system and re-designed the system to meet their unique needs, building a system based on relationships.

Considerations

Strategic alliances and partnerships have great potential to strengthen rural hospitals and change the trajectory of rural health care by building stronger networks, preventing closures and helping to preserve local availability of care. However, given the critical role of rural hospitals in the health and economy of local communities, participating organizations must carefully consider and select appropriate partnerships.

Some considerations in the selection process might include distance to an affiliate or partner health care system and transportation challenges for rural residents to get to partner institutions for specialty care. In addition, as a major employer as well as health care provider, rural hospitals need to consider possible effects on staff, including dissatisfaction or resistance to new policies and procedures and the possibility of reassignment or layoffs to increase efficiency. However, successful partnerships in rural areas across the country point to the potentially life- and job-saving nature of well-designed alliances.

Leadership Transformation

Background

While many of the problems involving rural health care involve technological limitations and financial challenges, many potential solutions are close at hand, too, in the form of passionate, transformative leaders.

Rural health care leaders often embody many of the same qualities found in rural communities as a whole, including:

- Strong sense of community and civic pride
- Ability to leverage diverse relationships for mutual benefit

- Resilience
- Resourcefulness
- Full of purpose

These leaders are often used to innovating out of necessity and doing more with fewer resources. They are skilled at strategically developing both local and far-flung partnerships and working across many communities and organizations to achieve their goals.

But at times, rural leaders may feel isolated. Given the relentless financial and logistical challenges rural hospitals face, leaders can be prone to burnout. They may also feel stretched too thin to welcome the new perspectives and innovations rural health facilities must embrace in order to survive.

The Task Force believes that rural communities need an investment in transformational leadership development for health care leaders. It is their position that visionary leaders are critical to innovation and sustained change in rural health care. Transformational leaders do more than just chart a path forward. They encourage and motivate others to think creatively and work together to mold a successful future for their organizations.

Toward this goal, rural hospitals can better leverage already-existing leadership training resources. The Task Force hopes more opportunities to expand scholarships and rural CEO preparation/mentoring programs will emerge in the near future. Looking farther ahead, the Task Force would like to see increased opportunities to standardize leadership training programs and incorporate change management principles, to create a steady stream

of incoming rural leaders with strong visions and the skills to execute those visions.

Solutions

Rural hospitals should explore existing leadership resources, including state hospital associations and professional organizations to help develop necessary skills for rural leaders. The AHA's annual Leadership Summit offers many such learning opportunities.[92] The Institute for Healthcare Improvement and the American College of Healthcare Executives are two of many other professional organizations that also offer robust health care leadership training resources.[93,94] While the COVID-19 pandemic has strained rural hospitals nearly to the breaking point, the migration of conferences and training sessions to an online format means these offerings may be more accessible to rural leaders in 2021 and perhaps beyond.

Additionally, rural institutions should explore pipeline programs with local educational institutions. These programs, which start as early as high school, help build training tracks for students to gain the necessary skills and education to become future leaders in their rural communities. One well-known example is the Health Careers Institute at Dartmouth, a summer program for high school students located in rural northern New Hampshire.[95]

The resources offered by Area Health Education Centers (AHECs) may help rural hospitals find pipeline programs with which to engage.[96] These state and local programs are committed to expanding the health care workforce, especially in underserved communities. They also maximize diversity and facilitate distribution of health care professionals. AHECs offer innovative, hands-on health careers curricula for high school and college students. During the 2019-2020 school year, AHECs placed 17,000 health careers students in rural and other underserved communities.

Advanced Education Opportunities

There are also opportunities to expand scholarships and rural CEO preparation/mentoring programs, in which individuals who demonstrate leadership skills are targeted earlier in their education or career (including high school, college or entry-level jobs) to develop pathways for future leaders.

Many leading universities throughout the U.S. offer innovative health care-related, advanced-degree programs. One notable example is the Master of Health Care Delivery Science (MHCDS) at Dartmouth College, which combines features of traditional MBA and MPH programs, with courses taught by faculty from Dartmouth's medical and business schools.[97] This low-residency program is offered mostly online and has recently been compressed from 18 to 12 months to encourage more working adults to enroll.

The Master of Science in Health Care Transformation offered by the University of Texas at Austin is a one-year, 30-credit-hour program. It specifically focuses on the principles of transformational leadership executives need to create lasting change by reorganizing health care around patients' needs.[98] Housed in the Austin McCombs School of Business, this program also involves faculty from the School of Medicine for a well-rounded perspective. It combines in-person and online coursework.

There has also been increased interest in growing the knowledge base of rural hospital leadership. For example, in 2018 the State of Georgia passed legislation that requires rural hospital executives and board members to complete training modules within one year of their initial appointment.[99] Each leader must also complete refresher training every two years thereafter. The Georgia Rural Health Innovation Center created the curriculum — which includes ethics, fiduciary responsibility and strategic planning — and monitors compliance. Although the roll-out was met with resistance by some health care organizations, many Georgia leaders have now come to embrace these requirements.

One Task Force member based in Georgia shared that some board members self-selected by resigning from the board when the requirement went into effect. These board members were replaced by more responsive trustees who are open to innovation. If his observations play out on a larger scale, the training requirement can raise the bar for rural hospital leaders who can pilot institutions to greater innovation and accomplishments.

The Task Force believes that the Georgia model shows promise and should be explored in other states. At the very least, if states mandated board and staff training but left the implementation and customization to individual institutions, local knowledge would advance considerably.

Standardized Training and Education

The Task Force believes the opportunity exists to further standardize educational and training programs so there is a steady stream of incoming visionary rural leaders. Local, state and federal incentive programs should be better coordinated to prevent duplication. Programs could offer free tuition for health care executives who are willing to serve in rural communities for a set number of years.

Some medical schools are already doing this for future clinicians. For example, the University of Alabama at Birmingham offers a five-year Rural Medicine Program that includes two years of clinical rotations at the University of Alabama at Huntsville Regional Medical and rural rotations and coursework.[100] Graduates agree to practice in an underserved area of the state.

The Task Force believes that this approach would also be successful in creating skilled rural executive leaders. Just as Alabama has tried to increase the supply of rural clinicians, the state has also sought to boost rural health care by creating the Alabama Rural Health Collective (ARHC).[101] The ARHC provides technical assistance to eligible hospitals on key topics like in a variety of areas, including compliance, purchasing, quality, strategic planning, provider recruitment and third-party partnerships. Another crucial ARHC offering is its RV-based mobile clinical simulation lab that travels the state to train clinical and administrative staff on ways to improve quality and the patient experience.

Alabama has cemented its commitment to rural health care by developing the rural health care administrative fellowship available as part of the UAB master's in health administration program.[102] The fellowship offers a comprehensive, multidisciplinary experience which consists of exposure to multiple areas and a diverse set of projects at a host rural hospital. This one-year program includes a competitive salary and benefits package from the host hospital and relocation assistance may be available.

The Task Force hopes that more such programs will become available to rural leaders over time. A network of standardized rural administrative fellowships could gradually transform standards of excellence in rural health care administration. Additionally, the Task Force believes that more states could offer incentives to both clinical and administrative leaders to focus on rural health care.

Considerations

Just as individual leaders have been instrumental in keeping rural hospitals afloat for so long, they offer great potential to help hospitals continue to adapt to changing conditions. But leaders' abilities to inspire change are limited when they themselves have settled into routine or find themselves resisting innovation due to a scarcity mindset. While legislative mandates can create resistance among board members and costs of training can be prohibitive in some situations, the Task Force feels these challenges can be overcome with forward and innovative thinking.

The Task Force believes that successful deployment of their recommendations is inextricably bound to a comprehensive effort – with allocated resources – to develop visionary leaders to drive the change that rural hospitals will need to thrive going forward.

Maternal Health

Background

Rural hospitals face significant financial and operational challenges as they struggle to provide maternity care to their communities. Despite being considered an essential service, rural OB units and service lines are being shut down throughout the United States. However, not offering an OB service line does not mean there will no longer be pregnancies and births in a community. It just means that women will have to travel farther to get the care they need, perhaps rendering them less likely to keep their prenatal appointments.

A 2017 *Health Affairs* study found that more than half of all rural U.S. counties lack hospital obstetric services, despite the fact that more than 28 million women of reproductive age lived in rural counties.[103] 9% of rural counties experienced the loss of all hospital obstetric services during the 10-year study period (2004-2014).

Many factors explain these closures, with the high cost of operations first and foremost. Additionally, the decentralized nature of rural populations means that any given rural hospital is likely to have relatively low volume for this service line relative to its cost structure. Other reasons for closures include:

- Difficulty recruiting and retaining obstetricians/ gynecologists
- Inadequate patient access
- Effects of the social determinants of health, including health disparities (especially in women of color and immigrant women), education levels and access to transportation.

But underlying these concerns is the relatively high rate of maternal death during pregnancy, birth and the postpartum period among women in the U.S. in general and in rural areas particularly. The Commonwealth Fund reports that women in the U.S. are the most likely to die from complications related to pregnancy or childbirth among developed countries.[104] In 2018, there were 17 maternal deaths for every 100,000 live births in the U.S. — a ratio more than double that of most other high-income countries. Rates of severe maternal morbidity and mortality compared are nearly 10% higher for rural U.S. residents compared to urban residents.[105] Among several key causes, these reports identify two that are especially common in rural areas: an inadequate supply of appropriate health care providers and a lack of maternal social supports.

According to the Centers for Disease Control and Prevention (CDC), 700 women per year die in the U.S. as a result of pregnancy or delivery complications, with American Indian/Alaska Native and Black women at substantially higher risk than white women.[106] More than 60% of pregnancy-related deaths occur in the time between delivery and one year postpartum. Additionally, 2 out of 3 maternal deaths were determined to be preventable. A recent study by the CDC also found that in Arizona, Native American women are dying of pregnancy-related causes at rate four times higher than white women.[107,108]

The infant mortality rate among American Indian and Alaska Native populations remains alarmingly high. American Indian and Alaska native infants are nearly twice as likely to die by their first birthday as non-Hispanic infants. Between 2005 and 2014, this was the only racial or ethnic group that did not experience a decline in infant mortality.[109]

For all of these reasons, the Task Force advocates for solutions that develop new care models to leverage the role of family medicine physicians and other qualified care providers to deliver routine maternal care. Additionally, the Task Force would also endorse the development of new payment models over time that reflect and reward this philosophy.

Solutions

In particular, the Task Force believes that the increased national awareness about the magnitude of the problem of pregnancy-related maternal deaths in the U.S. provides an opportunity to expand models and best practices that hold promise.

The Task Force would like to see expanded support for the Alliance for Innovation on Maternal Health (AIM) safety bundles.[110] AIM is a national partnership funded by the Health Resources and Services Administration's

(HRSA) Maternal and Child Health Bureau. It includes provider, public health and consumer groups that work at the state level to develop maternal safety bundles that include evidence-based practices.

These standardized maternal safety bundles have been shown to improve quality, safety and outcomes, including reduced rates of maternal mortality and severe maternal morbidity. Rural hospitals have benefited from participating in statewide collaborations, for example in California and Texas, around AIM maternal safety bundles.

Additionally, the Task Force endorses the expansion of three innovative models: expanded doula care in rural areas, the Pioneer Baby model and the CenteringPregnancy program.

Expand Doula Care in Rural Areas

Birth doulas are nonmedical personnel whose only focus during labor and childbirth is providing continuous emotional support to the mother. Studies have shown that using doulas can improve outcomes for mothers and infants, especially for women at risk of adverse outcomes, including African American and Hispanic women, and those living in rural areas.[111] Doulas have demonstrated a reduction in labor time, reduction of mother's anxiety, improvements in mother-baby bonding and improved breastfeeding success. A 2017 Cochrane systematic review, generally considered the highest standard of evidence, found improved outcomes for women and infants including shorter labors and decreased numbers of caesarean and instrumental vaginal births.[112]

Barriers to entry to becoming a doula are low, making the occupation well-suited to persons who live in rural areas and need additional work opportunities within their communities. Formal medical training is not required, although off-duty and retired nurses may find doula work to be a good part-time occupation. Several organizations provide voluntary certification programs for doulas.

As an example, Healthy Start Inc. serves both Allegheny and Westmoreland Counties in Pennsylvania — which includes both urban and rural areas. During the pandemic, the organization expanded accessibility of free doula support through virtual technology.[113] Extending this type of program nationally could help support pregnant women and improve maternal health outcomes in rural areas.

The widespread adoption of doula services to support rural laboring mothers still faces systemic challenges. With no licensure requirement or federal regulation in place to determine competencies, payers to date have not covered doula services, despite their strong record of quality improvements. This lack of insurance coverage and reimbursement for doula services can be challenging, making the work less financially viable for the practitioners unless it is supported by a health care system or private grant programs. Despite these challenges, some rural hospitals are responding to workforce challenges by engaging doulas, and the U.S. House of Representatives recently passed H.R. 4996, legislation that would pay for doula services. The Task Force encourages payers to reimburse for doula services.

Pioneer Baby Program

Launched six years ago at Kearny County Hospital (KCH) in Lakin, Kansas, the Pioneer Baby program focuses on improving pregnancy and birth outcomes among mothers with gestational diabetes. These women and their infants face an increased risk of both short- and long-term outcomes. A key feature of the program is a collaborative network, which includes public health organizations, medical schools and a federally qualified health center (FQHC). The program's success has helped ease the hospital's financial pressures associated with its maternity unit.

The Pioneer Baby initiative has four phases:

- **Phase 1:** Assess institutional needs and set clinical, quality or financial goals.
- **Phase 2:** Bring specialized care to the region to co-manage high-risk patients.

- **Phase 3:** Measure both clinical and financial results.
- **Phase 4:** Seek grant support from federal and local funders.

While this first application for the Pioneer Baby model focuses specifically on women with gestational diabetes, the Task Force believes this model can be applied more broadly to other pregnancy-related conditions.

CenteringPregnancy Program

Created by the March of Dimes, the CenteringPregnancy program brings together women due to give birth at the same time for group prenatal care appointments that last 90 minutes or more.[117] The additional time with providers allows patients to become more engaged and better informed and ask more in-depth questions. It also allows mothers to make friends and benefit from the support of other group members.

While bringing together a group of pregnant women of similar gestational age in rural communities is challenging, the American College of Obstetricians and Gynecologists (ACOG) reports that early research shows that group appointments offer several benefits, including reduced preterm births, increased rates of breastfeeding, decreased emergency department visits, improved patient satisfaction and improved knowledge of childbirth, family planning and postpartum depression.[118] CenteringPregnancy is a proven model that could bring great benefit to rural maternal care, if applied broadly throughout rural communities.

Considerations

In addition to what can be done in the near to mid-term, significant changes are needed to achieve widespread rural maternal health improvements in the future.

A key strategy to improve maternal care outcomes is to build the capacity of nurses, family physicians and health care providers to address maternity-related issues earlier, even before women become pregnant. While working to improve outcomes for women with gestational diabetes and their babies is crucial, for example, even greater benefit to mothers and babies would come from reaching women earlier so that they start their pregnancies on a healthier footing.

Changing Woman Initiative

Changing Woman Initiative is a nonprofit Native women's health collective with the mission "to renew cultural birth knowledge to empower and reclaim indigenous sovereignty of women's medicine and life way teachings to promote reproductive wellness, healing through holistic approaches and to strengthen women's bonds to family and community."[114] It focuses on creating a community based wellness model based on cultural teachings and belief systems using indigenous midwives and doulas, in order to improve maternal health outcomes for indigenous populations. Today there are only 14 Native American certified midwives across the country.[115]

The Changing Woman Initiative is currently planning to develop the nation's first Native birthing facility in New Mexico that will integrate ancient tribal birthing practices and break down barriers to receiving proper maternal care: limited transportation, food insecurity, lack of awareness of prenatal care and high costs. The birthing center provides an example of a women's health model that can be expanded for tribal communities nationwide.[116]

In order to reach women earlier in the life cycle, more upfront interventions are needed in the form of preventive programs and wellness care. As the Pioneer Baby model demonstrates, targeting creative fundraising and grants to obtain funding for specific high-impact positions — like maternal-child nurses who can develop holistic relationships with women of reproductive age in their communities — is a viable strategy. Pursuing grant funding for purchasing costly equipment and technology that enhances collaboration between local providers and out-of-town specialists should also be considered.

In general, rural hospitals often find it difficult to fully staff their obstetric and family medicine services, demonstrating the need for innovative recruitment and retention strategies. Administrators can explore partnerships with regional medical schools to create rotation opportunities at their institutions for medical trainees in family medicine and obstetrics.

There is also an urgent need for medical schools, health care administrators and rural hospitals to support the practice of full scope family medicine. The number of family physicians who provide maternity care has declined steeply in recent years, and even fewer practice surgical obstetrics. Although 21% of new family medicine graduates in 2016 reported an intention to include obstetric delivery in their scope of practice, only 7% of family physicians were actually doing so in that same year, according to the *Journal of the American Board of Family Medicine*.[119] Family medicine programs should incorporate maternity care into the vital training that family physicians receive during medical school and residency.

CMMI Pilot Project Focused on a Rural Maternal Health Model

CMMI should further disseminate state innovations and best practices. For example, the Task Force recommends expanding the Pioneer Baby model with further field testing as part of the proposed CMMI Rural Design Center (see page 38). If a CMMI pilot were successful, that would provide the vehicle needed to bring the model to scale throughout the rural U.S.

In September 2020, the House unanimously passed the following bills that now are under consideration by the Senate. These bills support the idea of expanding maternal health protections:

- **H.R. 4995.** The AHA supports passage of Maternal Health Quality Improvement Act (H.R. 4995) which aims to improve outcomes in rural and underserved areas by increasing access to maternity care, helping providers implement best practices. H.R. 4995 also provides funds to extend postpartum Medicaid coverage and helping to address racial and ethnic inequities.

- **H.R. 4996.** The AHA supports the Helping Medicaid Offer Maternity Services Act (H.R. 4996), which specifically addresses Medicaid coverage of doula care. It also encourages states to extend Medicaid and Children's Health Insurance Program coverage for pregnant and postpartum women from the current 60 days to one year after birth. The AHA also urges CMS to consider ways to increase coverage for maternal care through its waiver authority.

In addition, another bill has been introduced to specifically address health disparities and inequities in maternal health:

- **H.R. 6142.** AHA strongly supports the Black Maternal Health Momnibus Act (**H.R. 6142/S. 3424**), which would invest in community-based organizations, support care coordination and collect data on maternal mortality and morbidity in minority and underserved populations. The bill also would provide funding to diversify the maternal and perinatal nursing workforce to reflect the patient population served, create a perinatal care alternative payment model demonstration project and protect the health of pregnant incarcerated individuals. The AHA urges CMS to consider ways to use CMMI demonstration authority to explore how community-based organizations can improve maternal mortality and morbidity.

Develop New Maternal Health Payment Models

Looking even further ahead, the Task Force supports the creation of innovative payment models to support maternal health. As rural hospitals strengthen their maternal health service lines via the recommendations outlined above, payers can develop flexible payment models tied to quality outcomes that enable family physicians to expand their maternity services. Doing so would encourage the resurgence of full scope family medicine and create environments in which value-based reimbursement becomes feasible.

Rural Philanthropy

Background

Rural hospitals are anchor institutions in their communities as principal health care providers, major employers and key economic drivers in their regions. Despite these strengths, rural hospitals are also vulnerable. Providing care to geographically isolated and dispersed populations holds many challenges. Low patient volumes increase per-patient costs of care delivery and heavy reliance on government-funded programs like Medicare and Medicaid translates into lower reimbursement rates. For these and other reasons, many rural hospitals have operated on razor thin margins for years and the current pandemic has further exacerbated that financial strain.

Many rural organizations look to grants or donations to fill the revenue gap or augment state and federal funding. But applying for grants or soliciting donations is time-consuming with no guarantee of success. Allocating resources to devote to researching, applying for and administering grant programs is also difficult. Without dedicated staff who focus on alternative or creative funding opportunities, rural health care administrators may not be aware of resources available on the state or federal level to help them apply for and receive grants and other funding. Even if they apply for grants, hospitals may find they are competing with other organizations in their own communities for the same funds.

At the same time, funders often do not have a clear understanding of rural health or make the connection between their philanthropic goals and rural health care's needs. For example, COVID-19 has disproportionately impacted communities of color, and many funders have earmarked funds to address this. However, they may not associate rural hospitals with these goals, even though many do serve the target populations.[120] Developing relationships with leaders — including hospital executives — in rural areas can help funders gain a better understanding of shifting demographics in rural communities and the critical role rural hospitals can play in improving outcomes for immigrant populations, people of color and other marginalized groups.

Health care and health outcomes intersect with a wide range of policy issues. Funders focused on economic or social issues, conservation or technology may not think of rural hospitals as partners — and vice versa — even though monetary issues, housing, education, nutrition, the environment and access to technology are all social determinants of health that play a major role in a rural community's health outcomes.

Taking a more strategic approach to grants and philanthropic relationships, rethinking affiliations, tapping into available resources and working cooperatively with other community organizations may help hospitals and their communities develop innovative programs to improve health outcomes and realize financial goals more effectively.

Overview

Integrating philanthropy into a hospital's strategic plan should be a part of a long-term trajectory to promote investments in the health of a community. Forming long-term partnerships with funders and building relationships over time can lead to more funding opportunities and more secure financial footing for rural hospitals. These relationships are more likely to result from a series of conversations over time rather than a one-time application for a specific grant opportunity.

Hospital CEOs and administrators can and should take a lead role in these relationships — for example, by inviting potential funders to present their work or tour the hospital or community. But it does not have to fall solely on staff. Hospital trustees and advisory board members may have the time, resources and social or business networks needed to explore and forge relationships with potential funders.[121]

Resources to Help Identify Funding Opportunities

Resources are available to help identify funding opportunities:

- The USDA Rural Development has a variety of programs to support economic development and essential services — including health care — in rural communities.[122] USDA staff representatives for every state help communities access these programs.[123]
- The Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services offers a variety of resources for rural providers, including A Guide for Rural Health Care Collaboration and Coordination that discusses funding opportunities.[124]
- The Rural Health Information Hub, supported by HRSA, offers a comprehensive toolkit of emerging practices and resources for building philanthropic relationships.[125]
- The Federal Register lists all available federal grants and other funding opportunities, including those offered by the Department of Health and Human Services.[126] Most states have similar lists of grant opportunities from state agencies.

The Foundation Center has a directory of grant-making organizations and agencies to help identify potential funders, many of which do not have websites. The website offers some basic information for free, with additional resources available for subscribers. The database may also be available through some public and institutional libraries.[127]

Considerations

Hospitals should look at the wide spectrum of funders, including small, local foundations. Larger funders and government funders often are looking to build relationships in communities to improve health care and other social needs in rural areas. They need liaisons to identify communities in need of funding, and small funders often play that role. For example, during the pandemic, small funders have made connections between rural hospitals and state/federal officials and helped them access state and federal resources to address the situation.

Another largely untapped resource is local community colleges and regional universities. Faculty, students and alumni can all play roles in identifying funding opportunities, applying for grants, building programs and fostering new types of community collaborations to achieve mutual goals.

Other commercial businesses and organizations may be able to advocate for rural hospitals, assist in the design and implementation of new programs and help make necessary connections with funders. Hospitals should rethink and re-envision existing relationships with local businesses, facilities and organizations serving the same community — turning service relationships into strategic relationships. Referral relationships, economic relationships and even competitive relationships can evolve into collaborations around mutual interests. This type of community cooperation and strategic planning is often exactly what funders want to see because it increases the chance of success and impact.

CONCLUSION

The COVID-19 pandemic has taxed the U.S. health care system beyond anything it has ever experienced in modern history. A particular burden has fallen on rural hospitals, shining a light on weaknesses that have long existed in our rural health care system. Fortuitously, this light also illuminates the path to a future where we address these weaknesses by pursuing not just temporary fixes or minor tweaks, but whole scale transformations. Ideas that might have sounded radical before the pandemic, now seem like simple common sense.

These transformations will require time, money and focus that are all likely to be in short supply while the crisis continues. But the Task Force is certain that by adopting the measures set forth in this report — and consistently

building on them — we can reimagine the future of rural health care.

Working together on local, state and federal levels, we can transform rural health care into being what it always could and should have been: a powerful force not only for addressing the medical needs of our rural patients, but for achieving optimal health in rural communities.

SOURCES

1. Murphy T and Marema T. Rural Counties Face 5th Straight Week of Record Number of Covid-19 Deaths. Daily Yonder, Center for Rural Strategies. December 8, 2020. dailyyonder.com/rural-counties-face-5th-straight-week-of-record-number-of-covid-19-deaths/2020/12/08/. Accessed January 8, 2021.

2. United States Census Bureau. One in Five Americans Live in Rural Areas. August 9, 2017. www.census.gov/library/stories/2017/08/rural-america.html. Accessed January 12, 2021.

3. American Hospital Association. Rural Report: Challenges Facing Rural Communities and the Roadmap to Ensure Local Access to High-quality, Affordable Care. February 2019. www.aha.org/system/files/2019-02/rural-report-2019.pdf. Accessed January 8, 2021.

4. Defining Rural Population. Health Resources & Services Administration website. www.hrsa.gov/rural-health/about-us/definition/index.html. Accessed January 8, 2021.

5. American Hospital Association. Rural Report: Challenges Facing Rural Communities and the Roadmap to Ensure Local Access to High-quality, Affordable Care. February 2019. www.aha.org/system/files/2019-02/rural-report-2019.pdf. Accessed January 8, 2021.

6. Rural Hospital Closures: 2005 – Present. The Cecil G. Sheps Center for Health Services Research, University of North Carolina. www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/. Accessed January 8, 2021.

7. NRHA Save Rural Hospitals Action Center, National Rural Health Association. www.ruralhealthweb.org/advocate/save-rural-hospitals. Accessed January 8, 2021.

8. Eilrich FC, Doeksen GA, St Clair CF. The Economic Impact of Recent Hospital Closures on Rural Communities. National Center for Rural Health Works Research Study, July 2015. ruralhealthworks.org/wp-content/uploads/2018/04/Impact-of-HospitalClosure-August-2015.pdf. Accessed January 8, 2021.

9. About NRHA. National Rural Health Association website. www.ruralhealthweb.org/about-nrha/about-rural-health-care. Accessed January 8, 2021.

10. Office of the Assistant Secretary for Planning and Evaluation, US Department of Health and Human Services. ASPE Issues Brief: Rural Hospital Participation and Performance in Value-Based Purchasing and Other Delivery System Reform Initiatives. aspe.hhs.gov/system/files/pdf/211061/RuralHospitalsDSR.pdf. Accessed January 8, 2021.

11. Office of the Assistant Secretary for Planning and Evaluation, US Department of Health and Human Services. ASPE Issues Brief: Rural Hospital Participation and Performance in Value-Based Purchasing and Other Delivery System Reform Initiatives. aspe.hhs.gov/system/files/pdf/211061/RuralHospitalsDSR.pdf. Accessed January 8, 2021.

12. LaPointe J. Rural Hospital Closures Boost Mortality Rates by Nearly 6%. Practice Management News. September 3, 2019. revcycleintelligence.com/news/rural-hospital-closures-boost-mortality-rates-by-nearly-6. Accessed January 8, 2021.

13. Bai G, Anderson G. COVID-19 and the Financial Viability of US Rural Hospitals, Health Affairs Blog, July 1, 2020. www.healthaffairs.org/do/10.1377/hblog20200630.208205/full/. Accessed January 8, 2021.

14. Supplitt J. Blog: Rural hospitals innovate during COVID-19. American Hospital Association. August 7, 2020. www.aha.org/news/blog/2020-08-07-blog-rural-hospitals-innovate-during-covid-19. Accessed January 8, 2021.

15. Healthcare Access in Rural Communities. Rural Health Information Hub. www.ruralhealthinfo.org/topics/healthcare-access#services. Accessed January 8, 2021.

16. The Chartis Group: Chartis Center for Rural Health. The Rural Health Safety Net Under Pressure: Rural Hospital Vulnerability. February 2020. www.ivantageindex.com/wp-content/uploads/2020/02/CCRH_Vulnerability-Research_FiNAL-02.14.20.pdf. Accessed January 8, 2021.

17. North Carolina Rural Health Research Program, The Cecil G. Sheps Center for Health Services Research, University of North Carolina. Rural Health Snapshot (2017). www.shepscenter.unc.edu/wp-content/uploads/dlm_uploads/2017/05/Snapshot2017.pdf. Accessed January 8, 2021.

18. Fried JE, Liebers DT, Roberts ET. Sustaining Rural Hospitals After COVID-19: The Case for Global Budgets. JAMA. 2020;324(2):137–138. doi:10.1001/jama.2020.9744. jamanetwork.com/journals/jama/fullarticle/2767263

19. American Hospital Association. Rural Report: Challenges Facing Rural Communities and the Roadmap to Ensure Local Access to High-quality, Affordable Care. February 2019. www.aha.org/system/files/2019-02/rural-report-2019.pdf. Accessed January 8, 2021

20. Investing for the Future. Community Development Financial Institutions Fund, US Department of the Treasury. www.cdfifund.gov/Pages/default.aspx. Accessed January 8, 2021.

21. Kaufman K. Now, Near and Far: Planning Through Disruption in Healthcare. Kaufman, Hall and Associates, April 2019. www.kaufmanhall.com/sites/default/files/documents/2019-04/planning_through_disruption_in_healthcare_kaufmanhall.pdf. Accessed January 8, 2021.

22. Chung AP, Gaynor M, Richards-Shubik S. Subsidies and Structure: The Lasting Impact of the Hill-Burton Program on the Hospital Industry. National Bureau of Economic Research. February 2016. www.nber.org/system/files/working_papers/w22037/w22037.pdf. Accessed January 8, 2021.

23. Hawk J. Cornell signs innovative infrastructure agreement. News Center, Cornell College. August 22, 2019. news.cornellcollege.edu/2019/08/cornell-signs-innovative-infrastructure-agreement/. Accessed January 8, 2021.

24. US Dept. of Treasury. What does the CDFI Fund Do? Community Development and Financial Institutions Fund. www.cdfifund.gov/Pages/default.aspx. Accessed January 8, 2021.

25. Lukens J. CDFIs 'Make Dreams Come True' by Creating Opportunity in Rural Spaces. The Rural Monitor. Rural Health Information Hub website. December 19, 2019. www.ruralhealthinfo.org/rural-monitor/cdfis/. Accessed January 8, 2021.

26. Press release. Reps. Sewell, Reed Introduce Legislation to Help Finance Local Infrastructure Projects. Cong. Terri Sewell website. July 25, 2019. sewell.house.gov/media-center/press-releases/reps-sewell-reed-introduce-legislation-help-finance-local-infrastructure. Accessed January 8, 2021.

27. American Hospital Association. Task Force on Ensuring Access in Vulnerable Communities. November 29, 2016. www.aha.org/system/files/content/16/ensuring-access-taskforce-report.pdf. Accessed January 8, 2021.

28. American Hospital Association. Special Bulletin: Highlights of HHS Final Regulations to Modernize Stark and Anti-kickback. November 23, 2020. www.aha.org/special-bulletin/2020-11-23-special-bulletin-highlights-hhs-final-regulations-modernize-stark-and. Accessed January 8, 2021.

29. Schorow S. New Model for Rural Home Hospitalization. University of Utah Health. December 6, 2019. uofuhealth.utah.edu/newsroom/news/2019/12/ariadne-rural-homes.php. Accessed January 8, 2021.

30. Puderbaugh A. Iran's health houses provide model to improve rural health in the Mississippi Delta. Global Health Matters, Vol. 8, Issue 6. November - December 2009. Fogarty International Center,

National Institutes of Health. www.fic.nih.gov/News/GlobalHealthMatters/Pages/1209_health-house.aspx. Accessed January 8, 2021.

31. Greater New York Hospital Assn. Infrastructure Investments Critically Needed in Health Care and Workforce Development Initiatives. Position paper, March 13, 2019. www.gnyha.org/position/infrastructure-investments-critically-needed-in-health-care-and-workforce-development-initiatives/. Accessed January 8, 2021.

32. Model Design Factors. Center for Medicare and Medicaid Innovation, Centers for Medicare and Medicaid Services website. Undated. innovation.cms.gov/files/x/rfi-websitepreamble.pdf. Accessed January 8, 2021.

33. CHART Model. Center for Medicare and Medicaid Innovation, Centers for Medicare and Medicaid Services website. innovation.cms.gov/innovation-models/chart-model. Accessed January 8, 2021.

34. Center for Rural Health Policy Analysis, Rural Policy Research Institute. Innovation in Rural Health Care: Contemporary Efforts to Transform into High Performance Systems: Results of Roundtable discussions with Rural and Frontier Innovators: September 2013 and July 2015. ruralhealthvalue.public-health.uiowa.edu/files/Innovators_In_Rural_Health_Care_Delivery.pdf. Accessed on January 8, 2021.

35. Kamal R, McDermott D, Ramirez G, Cox C. How has U.S. spending on healthcare changed over time? Health System Tracker. Peterson-KFF website. www.healthsystemtracker.org/chart-collection/u-s-spending-healthcare-changed-time/#item-start. Accessed January 8, 2021.

36. Pennsylvania Rural Health Model. Centers for Medicare & Medicaid Services Innovation Center website. innovation.cms.gov/innovation-models/pa-rural-health-model. Accessed January 8, 2021.

37. Maryland All-Payer Model. Centers for Medicare & Medicaid Services Innovation Center website. innovation.cms.gov/innovation-models/maryland-all-payer-model. Accessed January 8, 2021.

38. Maryland Total Cost of Care Model. Centers for Medicare & Medicaid Services Innovation Center website. innovation.cms.gov/innovation-models/md-tccm. Accessed January 8, 2021.

39. Vermont All-Payer ACO Model. Centers for Medicare & Medicaid Services Innovation Center website. innovation.cms.gov/innovation-models/vermont-all-payer-aco-model. Accessed January 8, 2021.

40. Task Force on Ensuring Access in Vulnerable Communities. American Hospital Association website. www.aha.org/system/files/content/16/ensuring-access-taskforce-exec-summary.pdf. Accessed January 8, 2021.

41. Sharfstein JM, Gerovich S, Moriarty E, Chin DC. An Emerging Approach to Payment Reform: All-Payer Global Budgets for Large Safety-Net Hospital Systems. Commonwealth Fund website. www.commonwealthfund.org/publications/fund-reports/2017/aug/emerging-approach-payment-reform-all-payer-global-budgets-large. Accessed January 8, 2021.

42. Bai G, Yehia F, Chen W, Anderson GF. Varying Trends In The Financial Viability Of US Rural Hospitals, 2011-17. Health Affairs (Millwood). 2020 Jun;39(6):942-948. doi: 10.1377/hlthaff.2019.01545. PMID: 32479226. www.healthaffairs.org/doi/abs/10.1377/hlthaff.2019.01545. Accessed January 8, 2021.

43. NRHA Save Rural Hospitals Action Center, National Rural Health Association. www.ruralhealthweb.org/advocate/save-rural-hospitals. Accessed January 8, 2021.

44. Community Vitality and Rural Healthcare. Rural Health Information Hub. www.ruralhealthinfo.org/topics/community-vitality-and-rural-healthcare. Accessed January 8, 2021.

45. LaPointe J. Rural Hospital Closures Boost Mortality Rates by Nearly 6%. Practice Management News. September 3, 2019. revcycleintelligence.com/news/rural-hospital-closures-boost-mortality-rates-by-nearly-6. Accessed January 8, 2021.

46. Internal Revenue Service. Tax Cuts and Jobs Act: A comparison for businesses. October 21, 2020. Available from: www.irs.gov/newsroom/tax-cuts-and-jobs-act-a-comparison-for-businesses. Accessed January 12, 2021.

47. Tax Foundation. Tax Cuts and Jobs Act. taxfoundation.org/tax-reform-explained-tax-cuts-and-jobs-act/. Accessed January 12, 2021.

48. Opoku ST, Apenteng BA, Owens C, et al. Georgia Rural Hospital Tax Credit: Perspectives of Rural Health Executives. J Rural Health. 2020 Oct 28. doi: 10.1111/jrh.12529. Epub ahead of print. PMID: 33118217. onlinelibrary.wiley.com/doi/abs/10.1111/jrh.12529. Accessed January 8, 2021.

49. Georgia Department of Audits and Accounts Performance Audit Division. Rural Hospital Tax Credit: Requested Information on the Rural Hospital Tax Credit. Available from www.audits.ga.gov/rsaAudits/report/index. Accessed January 8, 2021.

50. Ellison A. State-by-state breakdown of 120 rural hospital closures. Becker's Hospital Review, January 15, 2020. www.beckershospitalreview.com/finance/state-by-state-breakdown-of-102-rural-hospital-closures.html. Accessed January 11, 2021.

51. Opoku ST, Apenteng BA, Owens C, et al. Georgia Rural Hospital Tax Credit: Perspectives of Rural Health Executives. J Rural Health. 2020 Oct 28. doi: 10.1111/jrh.12529. Epub ahead of print. PMID: 33118217. onlinelibrary.wiley.com/doi/abs/10.1111/jrh.12529. Accessed January 8, 2021.

52. American Hospital Association. Fact Sheet: Telehealth. February 2019. www.aha.org/system/files/2019-02/fact-sheet-telehealth-2-4-19.pdf. Accessed January 8, 2021

53. Barbash I et al. Rapidly Deploying Critical Care Telemedicine Across States and Health Systems During the Covid-19 Pandemic. NEJM Catalyst. July 22, 2020. catalyst.nejm.org/doi/full/10.1056/CAT.20.0301. Accessed January 8, 2021.

54. Stone R. How an Ohio-based Physician Organization Overcame Internal Hurdles and Launched a Telehealth Service as Covid-19 Shutdowns Loomed. NEJM Catalyst. October 8, 2020. catalyst.nejm.org/doi/full/10.1056/CAT.20.0515. Accessed January 8, 2021.

55. Mann D. et al. COVID-19 transforms health care through telemedicine: Evidence from the field. Journal of American Medical Informatics Assn. Volume 27, Issue 7, July 2020, Pages 1132–1135, doi.org/10.1093/jamia/ocaa072. academic.oup.com/jamia/article/27/7/1132/5824298?guestAccessKey=3621cf08-b2df-4027-b1f5-7dadadcd640f. Accessed January 8, 2021.

56. Monthly Telehealth Regional Tracker. FAIR Health website. www.fairhealth.org/states-by-the-numbers/telehealth. Accessed January 8, 2021.

57. Telehealth Programs. Federal Office of Rural Health Policy. Health Resources and Services Administration website. www.hrsa.gov/rural-health/telehealth. January 2021. Accessed January 8, 2021.

58. Whelan C. Addressing the Healthcare Crisis in Rural America. Huron Consulting.2019. www.huronconsultinggroup.com/insights/healthcare-crisis-rural-america. Accessed January 8, 2021.

59. Natafgi N, Shane DM, Ullrich F, MacKinney AC, Bell A, Ward MM. Using tele-emergency to avoid patient transfers in rural emergency departments: An assessment of costs and benefits. J Telemed Telecare. 2018;24(3):193-201. doi:10.1177/1357633X17696585. journals.sagepub.com/doi/abs/10.1177/1357633X17696585. Accessed January 8, 2021.

60. Telehealth Use in Rural Healthcare. Rural Health Information Hub. March 26, 2019. www.ruralhealthinfo.org/topics/telehealth. Accessed January 8, 2021.

61. State and Regional Telehealth Networks. American Hospital Association website. December 11, 2017. www.aha.org/2017-12-11-state-and-regional-telehealth-networks. Accessed January 8, 2021.

62. Mehrotra A, Jena AB, Busch AB, et al. Utilization of Telemedicine Among Rural Medicare Beneficiaries.

JAMA. 2016;315(18):2015–2016. doi:10.1001/jama.2016.2186, jamanetwork.com/journals/jama/fullarticle/2520619?resultClick=1. Accessed January 8, 2021.

63. State Telehealth Laws and Reimbursement Policies. Center for Connected Health Policy. National Telehealth Policy Resource Center. Fall 2019. www.telehealthresourcecenter.org/wp-content/uploads/2019/12/50-State-Telehealth-Laws-and-Reibmursement-Policies-Report-Fall-2019-FINAL.pdf. Accessed January 8, 2021.

64. National Consortium of Telehealth Resource Centers. Find Your TRC. www.telehealthresourcecenter.org/. Accessed January 8, 2021.

65. The University of New Mexico. Project Echo .hsc.unm.edu/echo/. Accessed January 12, 2021.

66. www.macfound.org/press/press-releases/finalists-named-competition-100-million-grant/

67. Press release. New Mexico Delegation Leads Bipartisan, Bicameral Effort to Expand Telehealth Care in Underserved Communities through Medicare and Medicaid. September 26, 2019. www.heinrich.senate.gov/press-releases/new-mexico-delegation-leads-bipartisan-bicameral-effort-to-expand-telehealth-care-in-underserved-communities-through-medicare-and-medicaid. Accessed January 8, 2021.

68. American Hospital Association. Special Bulletin: CMS Releases Additional Waivers for COVID-19. May 1, 2020. www.aha.org/system/files/media/file/2020/05/cms-releases-additional-waivers-for-covid-19-bulletin-5-1-2020.pdf. Accessed January 8, 2021.

69. American Hospital Association. Fact Sheet: The Future of Telehealth - Protecting Patient Access to Care. July 2020. www.aha.org/system/files/media/file/2020/07/fact-sheet-the-future-of-telehealth-protecting-patient-access-to-care.pdf. Accessed January 8, 2021.

70. Strover S. Reaching rural American with broadband internet service. The Conversation. January 16, 2018. theconversation.com/reaching-rural-america-with-broadband-internet-service-82488. Accessed January 8, 2021.

71. Fixed Broadband Deployment: Compare Broadband Availability in Different Areas. Federal Communications Commission website. December 2019. broadbandmap.fcc.gov/#/area-

72. U.S. Dept. of Veterans Affairs. VA partners with Microsoft to bring internet to more Veterans. Official blog. June 28, 2019. www.blogs.va.gov/VAntage/61913/multiple-vha-partnerships-work-bring-veterans-online/. Accessed January 8, 2021.

73. Office of the National Coordinator for Health Information Technology. What is the recommended bandwidth for different types of health care providers? HealthIT.gov. September 10, 2019. www.healthit.gov/faq/what-recommended-bandwidth-different-types-health-care-providers. Accessed January 8, 2021.

74. Pew Research Center. Smartphone Ownership Is Growing Rapidly Around the World, but Not Always Equally. February 5, 2019. www.pewresearch.org/global/2019/02/05/smartphone-ownership-is-growing-rapidly-around-the-world-but-not-always-equally/. Accessed January 8, 2021.

75. Gani, F. Will Connectivity Be The Next Cure? Health Care Implications Of 5G Cellular Technologies. Health Affairs Blog. October 30, 2020. www.healthaffairs.org/do/10.1377/hblog20201029.420234/full/. Accessed January 8, 2021.

76. Office of Virginia Governor Ralph S. Northam. Governor Northam Announces Broadband Expansion to Connect More Than 36,200 Homes, Businesses, and Community Groups. January 22, 2020. www.governor.virginia.gov/newsroom/all-releases/2020/january/headline-851106-en.html. Accessed January 8, 2021.

77. Illinois Dept. of Commerce. Gov. Pritzker Launches Connect Illinois, a $420 Million Statewide Broadband Expansion Under Rebuild Illinois. August 15,2019. www2.illinois.gov/dceo/Media/PressReleases/Pages/PR20190815.aspx. Accessed January 8, 2021.

78. Maine Legislature. An Act Regarding Telehealth.

June 13, 2019. www.mainelegislature.org/legis/bills/getPDF.asp?paper=SP0383&item=3&snum=129. Accessed January 8, 2021.

79. Anderson J. Maine's Telehealth Hopes Need Broadband to Become Reality. Portland Press Herald, reprinted in Government Technology. July 29, 2019. www.govtech.com/health/Maines-Telehealth-Hopes-Need-Broadband-to-Become-Reality.html. Accessed January 8, 2021.

80. Maine Broadband Coalition. www.mainebroadbandcoalition.org/. www.mainebroadbandcoalition.org/. Accessed January 8, 2021.

81. Mannino, G. Mills announces nearly $6M to build internet infrastructure in rural Maine communities. Newscenter Maine. November 20, 2020. www.newscentermaine.com/article/money/mills-announces-nearly-6m-to-build-internet-infrastructure-in-rural-maine-communities/97-cda32e5d-3dea-41b3-8556-fb1b3336d06e. Accessed January 8, 2021.

82. deWit K. States Tap Federal CARES Act to Expand Broadband. Pew Trusts. November 16, 2020. www.pewtrusts.org/en/research-and-analysis/issue-briefs/2020/11/states-tap-federal-cares-act-to-expand-broadband. Accessed January 8, 2021.

83. Bridging The Digital Divide For All Americans. Federal Communications Commission website. Undated. www.fcc.gov/about-fcc/fcc-initiatives/bridging-digital-divide-all-americans. Accessed January 8, 2021.

84. Connected Care Pilot Program. Federal Communications Commission website. December 16, 2020. www.fcc.gov/wireline-competition/telecommunications-access-policy-division/connected-care-pilot-program. Accessed January 8, 2021.

85. Lagasse J. COVID-19 is forcing rural hospitals to rethink their business models. Healthcare Finance. July 9, 2020. www.healthcarefinancenews.com/news/covid-19-forcing-rural-hospitals-re-think-their-business-models. Accessed January 8, 2021.

86. Coker Group. Presentation to the AHA Future of Rural Task Force on August 5, 2020. Used with permission.

87. Lagasse J. COVID-19 is forcing rural hospitals to rethink their business models. Healthcare Finance. July 9, 2020. www.healthcarefinancenews.com/news/covid-19-forcing-rural-hospitals-re-think-their-business-models. Accessed January 8, 2021.

88. Whelan C. Addressing the Healthcare Crisis in Rural America. Huron Consulting website. www.huronconsultinggroup.com/insights/healthcare-crisis-rural-america. Accessed January 8, 2021.

89. Health Research & Educational Trust. (2013, June). The role of small and rural hospitals and care systems in effective population health partnerships. Chicago, IL: Health Research &Educational Trust. www.hpoe.org/small-rural-partnerships. Accessed January 8, 2021.

90. Health Research & Educational Trust. (2013, June). The role of small and rural hospitals and care systems in effective population health partnerships. Chicago, IL: Health Research &Educational Trust. www.hpoe.org/small-rural-partnerships. Accessed January 8, 2021.

91. Gottlieb K. The Nuka System of Care: improving health through ownership and relationships. Int J Circumpolar Health. 2013;72:10.3402/ijch.v72i0.21118. Published 2013 Aug 5. doi:10.3402/ijch.v72i0.21118. www.ncbi.nlm.nih.gov/pmc/articles/PMC3752290/. Accessed January 8, 2021.

92. AHA Leadership Summit. American Hospital Association website. www.aha.org/topics/aha-leadership-summit. Accessed January 8, 2021.

93. IHI Fellowship Program. Institute for Healthcare Improvement website. www.ihi.org/engage/fellowships/Pages/default.aspx. Accessed January 8, 2021.

94. Career Resource Center. American College of Healthcare Executives website. www.ache.org/career-resource-center. Accessed January 8, 2021.

95. Health Careers Institute at Dartmouth. Dartmouth Institute for Health Policy & Clinical Practice website.

tdi.dartmouth.edu/health-careers-institute. Accessed January 8, 2021.

96. What AHECs Do. National Area Health Education Centers (AHEC) website. www.nationalahec.org/page/WhatAHECsDo. Accessed January 8, 2021.

97. Program Homepage. Master of Health Care Delivery Science. Dartmouth College website. mhcds.dartmouth.edu/. Accessed January 8, 2021.

98. Academics. Master of Science in Health Care Transformation. University of Texas website. www.mccombs.utexas.edu/Master-of-Science-in-Health-Care-Transformation/Academics. Accessed January 8, 2021.

99. Training Criteria & Guidelines. Georgia Rural Health Innovation Center website. www.georgiaruralhealth.org/hospital-leadership-training/criteria-guidelines/. Accessed January 8, 2021.

100. Rural Medicine Program. University of Alabama at Birmingham website. www.uab.edu/medicine/home/education/md-program/rural-medicine/rural-medicine-program. Accessed January 8, 2021.

101. About the ARHC. Alabama Rural Health Collaborative website. arhcresourcecenter.org/. Accessed January 8, 2021.

102. Administrative Fellowship. UAB Medicine website. www.uabmedicine.org/web/careers/browse-job-types/adminfellow. Accessed January 8, 2021.

103. Hung P, Henning-Smith CE, Casey MM, Kozhimannil KB. Access To Obstetric Services In Rural Counties Still Declining, With 9 Percent Losing Services, 2004-14. Health Aff (Millwood). 2017 Sep 1;36(9):1663-1671. doi:10.1377/hlthaff.2017.0338.

104. Tikkanen R, Gunja MZ, FitzGerald M, Zephyrin L. Maternal Mortality and Maternity Care in the United States Compared to 10 Other Developed Countries. Commonwealth Fund website. November 18, 2020. www.commonwealthfund.org/publications/issue-briefs/2020/nov/maternal-mortality-maternity-care-us-compared-10-countries. Accessed January 8, 2021.

105. Kozhimannil KB, Interrante JD, Henning-Smith C, Admon LK. Rural-Urban Differences In Severe Maternal Morbidity And Mortality In The US, 2007–15. Health Affairs (Millwood). 2019 Dec;38(12). doi.org/10.1377/hlthaff.2019.00805

106. Maternal Mortality. Reproductive Health. Centers for Disease Control and Prevention website. www.cdc.gov/reproductivehealth/maternal-mortality/index.html. Accessed January 8, 2021.

107. Petersen EE, Davis NL, Goodman D, Cox S, et al. Racial/Ethnic Disparities in Pregnancy-Related Deaths — United States, 2007–2016. MMWR. 2019, September 6;68(35):762–765. www.cdc.gov/mmwr/volumes/68/wr/mm6835a3.htm.

108. Morales L. Indigenous Initiative Seeks To Reduce Maternal Mortality Rate. KJZZ 91.5 FM website. kjzz.org/content/1276156/indigenous-initiative-seeks-reduce-maternal-mortality-rate. November 1, 2019. Accessed January 8, 2021.

109. Truschel L, Novoa C. American Indian and Alaska Native Maternal and Infant Mortality: Challenges and Opportunities. Center for American Progress website. July 9, 2018. www.americanprogress.org/issues/early-childhood/news/2018/07/09/451344/american-indian-alaska-native-maternal-infant-mortality-challenges-opportunities/. Accessed January 8, 2021.

110. Patient Safety Bundles. Alliance for Innovation on Maternal Health website. safehealthcareforeverywoman.org/aim/patient-safety-bundles/#core. Accessed January 8, 2021.

111. Dekker R. Evidence on: Doulas. Evidence Based Birth website. May 4, 2019. evidencebasedbirth.com/the-evidence-for-doulas/. Accessed January 8, 2021.

112. Bohren MA, Hofmeyr GJ, Sakala C, Fukuzawa RK, Cuthbert A. Continuous support for women during childbirth. Cochrane Database Syst Rev. 2017 Jul 6;7(7):CD003766. doi: 10.1002/14651858.CD003766.pub6.

113. Pittsburgh Doulas Address Maternal Health Crisis During COVID-19. Pittsburgh Newswire. April 24,

2020. pittsburghnewswire.com/2255/pittsburgh-doulas-address-maternal-health-crisis-during-covid-19/. Accessed January 8, 2021.

114. Who We Are. Changing Woman Initiative website. www.changingwomaninitiative.com/about.html. Accessed January 8, 2021.

115. Loftman PO, Gonzales N. Indigenous Midwifery: Reclaiming, Restoring, and Rebuilding. Quickening. 2017;48(4):12-15. www.midwife.org/acnm/files/ccLibraryFiles/Filename/000000006827/Fall17_F17_FINAL_11_21_2017_OPTIMIZED.pdf. Accessed January 8, 2021.

116. CWI Traditional Birth Center Native American Centered Women's Health Collective. Changing Woman Initiative website. www.changingwomaninitiative.com/cwi-traditional-birth-center.html. Accessed January 8, 2021.

117. Enhanced Prenatal Care. March of Dimes website. www.marchofdimes.org/mission/enhanced-prenatal-care.aspx. Accessed January 8, 2021.

118. Group Prenatal Care. Committee Opinion Number 731, March 2018. American College of Obstetricians and Gynecologists website. www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2018/03/group-prenatal-care. Accessed January 8, 2021.

119. Barreto TW, Eden AR, Petterson S, Bazemore AW, Peterson, LE. Intention Versus Reality: Family Medicine Residency Graduates' Intention to Practice Obstetrics. J Am Board of Family Medicine. 2017 July;30(4):405-406. DOI: doi.org/10.3122/jabfm.2017.04.170120.

120. Swierzewski, R. Rural Philanthropy: Building Dialogue From Within. National Committee for Responsive Philanthropy, August 2007. community-wealth.org/sites/clone.community-wealth.org/files/downloads/report-swierzekski.pdf. Accessed on January 8, 2021.

121. Lewis J and Smart A. Rural Philanthropy as a Long-term Strategy. Advancing Health podcast, August 2020. www.aha.org/advancing-health-podcast/2020-07-29-rural-philanthropy-long-term-strategy. Accessed on January 8, 2021.

122. About Rural Development. U.S. Department of Agriculture website. www.rd.usda.gov/about-rd. Accessed on January 8, 2021.

123. State Offices of Rural Development. U.S. Department of Agriculture website. www.rd.usda.gov/page/state-offices. Accessed on January 8, 2021.

124. Health Resources & Services Administration, US Department of Health and Human Services. A Guide for Rural Health Care Collaboration and Coordination. August 2019. www.hrsa.gov/sites/default/files/hrsa/ruralhealth/resources/hrsa-rural-collaboration-guide.pdf. Accessed January 8, 2021.

125. Rural Philanthropy Toolkit. Rural Health Information Hub. www.ruralhealthinfo.org/toolkits/philanthropy. Accessed January 8, 2021.

126. Health and Human Services Grants & Funding. Federal Register: The Daily Journal of the United States Government, National Archives. www.federalregister.gov/health-and-human-services-grants-funding. Accessed January 8, 2021.

127. Quick Start. Foundation Directory Online website. fconline.foundationcenter.org/welcome/quick-start. Accessed on January 8, 2021.

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May 2021

Charter

Quality Committee
Tahoe Forest Hospital District
Board of Directors

PURPOSE:

The purpose of this document is to define the charter of the Quality Committee of the District's Board of Directors and, further, to delineate the Committee's duties and responsibilities.

RESPONSIBILITIES:

The Quality Committee shall function as the standing committee of the Board responsible for providing oversight for Quality Assessment and Performance Improvement, assuring the hospital's quality of care, patient safety, and patient experience.

DUTIES:

1. Recommend to the Board, as necessary, policies and procedures governing quality care, patient safety, environmental safety, and performance improvement throughout the organization.
2. Assure the provision of organization-wide quality of care, treatment, and service provided and prioritization of performance improvement throughout the organization.
3. Monitor the improvement of care, treatment, and services to ensure that it is safe, beneficial, patient-centered, customer-focused, timely, efficient, and equitable.
4. Monitor the organization's performance in national quality measurement efforts, accreditation programs, and subsequent quality improvement activities.
5. Monitor the development and implementation of ongoing board education focusing on service excellence, performance improvement, risk-reduction/safety enhancement, and healthcare outcomes.

COMPOSITION:

The Committee is comprised of at least two (2) board members as appointed by the Board President and two (2) members of the Tahoe Forest Hospital District Medical Staff as appointed by the Medical Executive Committee (Recommend Chief of Staff or designee and Chairperson of the Quality Assessment Committee).

MEETING FREQUENCY:

The Committee shall meet quarterly.