TAHOE FOREST HOSPITAL DISTRICT

2018-11-06 Board Quality Committee Meeting

Tuesday, November 6, 2018 at 12:00 p.m.

Eskridge Conference Room - Tahoe Forest Hospital

10121 Pine Avenue, Truckee, CA 96161

Meeting Book - 2018-11-06 Board Quality Committee Meeting

11/06/18 Board Quality Committee

TAHOE FOREST HOSPITAL DISTRICT

QUALITY COMMITTEE AGENDA

Tuesday, November 6, 2018 at 12:00 p.m.
Eskridge Conference Room, Tahoe Forest Hospital
10121 Pine Avenue, Truckee, CA

1. CALL TO ORDER

2. ROLL CALL
Alyce Wong, RN, Chair; Charles Zipkin, M.D., 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: 08/09/2018 .....**ATTACHMENT**

6. ITEMS FOR COMMITTEE DISCUSSION AND/OR RECOMMENDATION

6.1. Safety First

6.2. Patient & Family Centered Care (PFCC)

6.2.1. Follow up from Patient Experience Presentation
Provide status report on Mental Health coordination and resources for patients in our community.

6.2.2. Patient & Family Advisory Council 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..... ATTACHMENT
Provide update regarding the Beta Healthcare Group culture of safety program.

6.3.2 Beta Quest for Zero Harm Recognition..... ATTACHMENT
Share Beta Healthcare Group Quest for Zero Harm recognition in Obstetrics and Emergency Care.

6.4. Hospital Compare Star Rating ..... ATTACHMENT
Provide update regarding the Hospital Compare star rating program.

6.5. Complaint/Grievance Policy……ATTACHMENT
Provide overview of the Complaint/Grievance Policy (AGOV-24) and the Grievance Committee functions to address patient complaints.

6.6. Board Quality Education .....ATTACHMENT
The Committee will review and discuss the CMS Rural Health Strategy (2018) Retrieved June 7, 2018 from *https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Rural-Strategy-2018.pdf*

7. REVIEW FOLLOW UP ITEMS / BOARD MEETING RECOMMENDATIONS

8. NEXT MEETING DATE

The date and time of the next committee meeting 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 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 (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

QUALITY COMMITTEE
DRAFT MINUTES

Thursday, August 9, 2018 at 9:00 a.m.
Eskridge Conference Room, Tahoe Forest Hospital
10121 Pine Avenue, Truckee, CA

1. CALL TO ORDER
Meeting was called to order at 9:02 a.m.

2. ROLL CALL
Board: Alyce Wong, RN, Chair; Charles Zipkin, M.D., Board Member

Staff in attendance: Harry Weis, Chief Executive Officer; Janet Van Gelder, Director of Quality and Regulations; Jean Steinberg, Director of Medical Staff Services

Other: Jeannie Webb, California Department of Public Health Surveyor

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: 05/08/2018
Director Zipkin moved approval of the May 8, 2018 Board Quality Committee minutes, seconded by Director Wong.

6. ITEMS FOR COMMITTEE DISCUSSION AND/OR RECOMMENDATION

6.1. Safety First
Safety First has become part of the Health System's culture. Administrative and medical staff meetings now start with a Safety First topic. Quality Committee would like to see Safety First added as an agenda item for the board meetings.

6.2. Patient & Family Centered Care (PFCC)

6.2.1. Follow up on previous Patient Experience presentation
CEO provided an update that the Health System is in the early stages of developing a behavioral health program. The Health System made a hiring commitment to a mental health Physician Assistant (PA). The PA is going through the credentialing process and will arrive in October. He will work under the supervision of psychiatrist Gayle Pritchard. The hospital is also working on telepsychiatry consults to be available in the emergency room.

Dr. Peter Taylor, Medical Director of Quality, joined the meeting at 9:11 a.m.

Discussion was held about the setup of telepsychiatry services.

CDPH surveyor added that University of Pacific has a Nurse Practitioner program certified in psych program.

Discussion was held about the recent patient presentation on pain control. Dr. Koch will be more actively involved in palliative care going forward. Director of Quality and Regulations will make sure Dr. Koch is aware of the gaps that patient expressed.

6.2.2. Patient & Family Advisory Council Update

An update was provided related to the activities of the Patient and Family Advisory Council (PFAC).

PFAC does not meet in summer months due to vacation schedules.
The committee has a new male recruit. Patti Johnson will interview him to be sure he is a good fit.

Lorna Tirman, Patient Experience Specialist, joined the meeting at 9:17 a.m.

Patient Experience Specialist would like PFAC member Patti Johnson to join Board Quality Committee as a volunteer representative.

Ms. Webb departed the meeting at 9:19 a.m.

The committee discussed the Health System's internal CARE committee.

6.3. Performance Improvement Initiatives

Director of Quality provided a status report on the Quality Assurance/Performance Improvement Plan (#AQPI-05) priorities for 2018.

PFAC is discussed at every board quality meeting. Quality would like to pull together a team to look at next steps for patient and family centered care.

Lean principles are promoted as part of our culture. Director of Quality noted to leave "lean principles" on the list and keep it visible. Director Wong reminded the committee it would look at removing it since it would be part of the process.

Any gaps in EPIC are tracked by Jeff Rosenfeld. The Health System is not receiving the quality report from EPIC that it expected so another module will be added.

CEO updated the committee about hospital versus physician billing. The board will hear more about this at the next board meeting.

Dr. Shawni Coll, Chief Medical Officer, joined at 9:34 a.m.

PRIME updates are scheduled at June and December board meetings.

Two physicians coming on board with suboxone certification which will help decrease non-malignant pain drug use.

6.4. Patient Safety

6.4.1. Beta HEART Program

There is a lot of education going on around the BETA HEART program. The Health System will send 10-12 people to training in October.

CMO explained the disclosure process which includes a physician advocate, a quality department team member and plus or minus the physician involved (could depend on situation or physician social skills).

Quality is in the process of meeting with staff and creating an action plan from the results of the SCORE survey. This will be reported to the full board when it is complete. BETA requires use of the SCORE survey.

The Care for the Caregiver program is also a component of the HEART program.

Director Zipkin inquired if the District receives a reduction in premium for participating. Yes, a reduction in premiums is received for participation in the program. The District does not have to provide data after the fact but does have to have policies and programs in place, etc.

OB has received Tier II which is a harder to obtain than Tier I because all staff has to participate in the training.

The committee will look forward to hearing an update after the October conference.

6.5. Quality Star Rating

Director of Quality reviewed the Hospital Compare Quality star rating program overview on page 14 of the packet. 57 quality measures are submitted.

The majority of hospitals receive a 3-star rating. Tahoe Forest Hospital averages a 4-star rating. The ratings are a year behind.

Tahoe Forest is back up to 5-star for the HCAPHS rating. This is visible to public.

Incline Village Community Hospital does not have enough statistically significant data to have a ranking.

"Choosing Wisely" colleges chose top radiological procedures and our Health System has been looking at those for a long time.

6.6. Board Quality Education

The Committee will review and discuss topics for future board quality education. Identify best practice topics for review at future meetings.

6.6.1. The Joint Commission (2017). The essential role of leadership in developing a safety culture. *Sentinel Event Alert*, 57.

Discussion was held on the hospital's culture of safety and what the next steps are.

CMO asked the committee to bring Safety First forward to the board meeting. Safety affects every area from clinical to billing and IT. Director Zipkin agreed and felt it is a top down event. Safety First will rotate between AC member so it is not presented from the same person every month.

Director Wong will send an email to Board President to add Safety First to the board agenda. Director of Quality will keep this article in mind for development next year.

6.6.2. Patient Safety Network (2017). High Reliability. *Patient Safety Primer,* 31.

No discussion was held.

7. REVIEW FOLLOW UP ITEMS / BOARD MEETING RECOMMENDATIONS

-review Grievance Committee process

8. NEXT MEETING DATE

The next Board Quality Committee meeting will be on November 6, 2018 at 12:00 p.m.

9. ADJOURN

Meeting adjourned at 10:14 a.m.

Patient and Family Advisory Council Summary Report

July 2018 to November 2018

Submitted by: Lorna Tirman, Patient Experience Specialist

- The Tahoe Forest Hospital Advisory Council meets every month 9 months in the year. We do not meet July, August or December. There are currently 8 active members.
- Council agreed in January that their work will be aligned with hospital plan to assist leadership in creating the perfect care experience.
- Meetings are focused on improving processes and behaviors to continue to provide the Perfect Care Experience to our community and visitors.
- Plan for 2018-2019 is to review patient feedback and comments from patient experience surveys.
- Currently reviewing top performing service areas and focusing on service areas that are lowest performing.
- Reviewed history of patient experience and evolution of Patient Advisory Councils. Discussion about how patient experience and quality of care are related.
- Communication is a large part of a care experience.
- Engaged council in how to improve Patient Experiences in our lowest scoring service areas, outpatient and multispecialty clinics.
- Council defined behaviors would be ideal to create a perfect care experience. CARE= Connect, Ask, Respect and Respond, Educate with Empathy. Will take these ideas to CARE committee.
- Advisory council recommended we encourage all patients to return surveys. Scripting sent to all leaders to share with staff to encourage patients and families to send back their feedback if they receive a survey.
- Reviewed Quality Website Community facing information and gave input on what they would like to see as far as layout and specific metrics and information.

Next Meeting: November 13, 2018

Beta HEART Program Update

HEART = Healing, Empathy, Accountability, Resolution, Trust

Dawn Lockwood, Patient Safety Specialist

- 7 TFHD staff, including 2 physicians and CMO, attended Beta HEART Conference #1 in February
    - Focus on Culture of Safety and initial discussion of Rapid Response to Events

- TFHD Staff, additionally 1 ED physician, attended Beta HEART conference #2 in May
    - Focus on Rapid Event Response, Care for the Caregiver, and in depth Communication and Transparency training

- SCORE (*Safety, Communication, Operational Reliability, and Engagement)* Culture of Safety Survey completed in March
    - 64% response rate, with 48 providers
    - Results have been shared with all department leaders and AC. Key areas for opportunity overall include
        - Teamwork (inter and intra- departmental)
        - Improving feedback and performance expectations to staff (by leadership)
        - Continuing to work on technology process improvement (EPIC)
    - Survey results and debriefing sessions with department staff are occurring throughout July and August
    - Department Leadership will receive feedback from staff debriefing sessions and develop goals for improving

- Disclosure and Care for the Caregiver policies have been reviewed and updated by team.
    - Education to Medical Staff and TFHD staff has begun and is ongoing.

- 3rd Beta HEART conference was October 18-19, 2018 with 8 staff, including 2 physicians, in attendance
    - Focus on early resolution process and stakeholder consensus

- Plan to participate in 2019 and identify other key staff to attend educational sessions

BETA HEALTHCARE GROUP | OB INITIATIVE

QUEST FOR ZERO: Excellence in OB

It is an honor and a privilege to congratulate

Tahoe Forest Hospital

for your commitment to deliver optimal perinatal care in our joint effort to reach zero preventable harm.

I would like to recognize your perinatal team's outstanding achievement for having met Tier 1 and Tier 2 requirements of

BETA Healthcare Group's Quest for Zero: OB initiative in 2018.

In your seventh year of participation, we know you are making an impact in the lives of moms and babies by implementing strategies focused strategies focused on Interdisciplinary Strip Review and 2nd Stage of Labor Management.

Congratulations for making a difference in the lives of families!

TOM WANDER
CHIEF EXECUTIVE OFFICER
BETA HEALTHCARE GROUP

BETA*rm OB
SAFETY & CARE — UNITED

BETA HEALTHCARE GROUP | ED INITIATIVE

QUEST FOR ZERO: Excellence in ED

It is my distinct privilege to congratulate

Tahoe Forest Hospital

for your commitment to constant improvement as, together,
we strive to eliminate preventable harm to those in need of emergent care.

I would like to recognize your team's commendable achievement
for having met Tier 1 requirements of

BETA Healthcare Group's Quest for Zero: ED initiative in 2018.

In your seventh year of participation, a significant impact
is being made to the lives of those entrusted to your care.

Congratulations for making quality of care a priority!

TOM WANDER
CHIEF EXECUTIVE OFFICER
BETA HEALTHCARE GROUP

BETA*rm ED
SAFETY & CARE—UNITED

BETA HEALTHCARE GROUP | ED INITIATIVE

QUEST FOR ZERO: Excellence in ED

It is my distinct privilege to congratulate

Tahoe Forest Hospital- Incline Village

for your commitment to constant improvement as, together,
we strive to eliminate preventable harm to those in need of emergent care.

I would like to recognize your team's commendable achievement
for having met Tier 1 requirements of

BETA Healthcare Group's Quest for Zero: ED initiative in 2018.

In your fifth year of participation, a significant impact
is being made to the lives of those entrusted to your care.

Congratulations for making quality of care a priority!

TOM WANDER
CHIEF EXECUTIVE OFFICER
BETA HEALTHCARE GROUP

BETA*rm ED
SAFETY & CARE—UNITED

July 2018 *Hospital Compare* Release
Frequently Asked Questions

July 2018 Data Updates

Q. Will CMS update the Overall Hospital Star Ratings on *Hospital Compare* in July 2018?
A. CMS will not update the Overall Hospital Star Ratings on the *Hospital Compare* website for July 2018. The Overall Hospital Star Ratings posted in December 2017 will continue to remain on the *Hospital Compare* site until updated at a future date.

The Overall Hospital Star Ratings confidentially provided to hospitals in May 2018 through preview reports and Hospital-Specific Reports (HSRs) will not be publicly reported.

Q. How is CMS addressing stakeholder concerns about the sensitivity of the Hospital Overall Star Ratings to measure changes?

A. The Overall Hospital Star Ratings is designed to summarize hospitals' performance on publicly reported measures. CMS is dedicated to transparency of quality and cost information for consumers, and committed to holding providers accountable for patient outcomes. When changes are made to the underlying measures it is vital to take the time needed to understand the impact of those changes and ensure we are giving consumers the most useful information. As part of this process, CMS will seek feedback from a multi-disciplinary Technical Expert Panel, a Provider Leadership Workgroup, and a public comment period.

Q. What data will CMS refresh, add, or remove in this release?
A. CMS will update data for the following Hospital Inpatient Quality Reporting (IQR) Program/Hospital Outpatient Quality Reporting (OQR) Program measure groups:

- Outcome measures: 30-day mortality, 30-day readmissions, and CMS Patient Safety Indicators
- Outpatient imaging efficiency
- Payment and value of care
- Timely and effective care
- Healthcare-associated infections (HAI)
- Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey

CMS will be adding three new measures to *Hospital Compare*:

- Hospital return days for pneumonia patients (EDAC-30-PN)
- Percentage of patients who received appropriate care for severe sepsis and septic shock (SEP-1)
- Average time patients spent in the emergency department before being sent home (OP-18c) (will only be reported on data.medicare.gov)

CMS is no longer reporting the Pain Management composite 4 on *Hospital Compare* or in the downloadable databases. This composite measure is also being excluded from the calculation of the HCAHPS Summary Star Rating for the July *Hospital Compare* release.

CMS will also update data for the following quality reporting programs:

- Comprehensive Care for Joint Replacement Model
- Prospective Payment System-Exempt Cancer Hospital (PCH) Quality Reporting Program
- American College of Surgeons National Surgical Quality Improvement Program (ACS NSQUIP®)

The Outpatient and Ambulatory Surgical Center Consumer Assessment of Healthcare Providers and Systems (OAS CAHPS) data will be refreshed for those facilities that voluntarily participate in the survey.

The July 2018 update will also include updated data for Veterans Administration (VA) Medical Centers and military hospitals:

- 30-day death and readmissions
- Serious complications and deaths (AHRQ measures)
- Survey of Healthcare Experiences of Patient (SHEP) (VA)
- TRICARE Inpatient Satisfaction Surveys (TRISS) (military hospitals)
- Timely & effective care (VA, military hospitals)

Q. Where can hospitals find more information on the Overall Hospital Quality Star Rating?
A. More information on the Overall Star Rating is available on the following sites:

- QualityNet
  https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228775183434

- *Hospital Compare*
  - About *Hospital Compare* – https://www.medicare.gov/hospitalcompare/About/Hospital-overall-ratings.html
  - About the Data – https://www.medicare.gov/hospitalcompare/Data/Hospital-overall-ratings-calculation.html

Q. Where can I submit questions about the Overall Hospital Quality Star Rating on *Hospital Compare*?
A. Submit questions about the methodology to: cmsstarratings@lantanagroup.com

Q. What is the purpose of the Data Updates file?
A. The Data Updates file provides an overview of which datasets CMS refreshed for each release. This file does not provide program updates. QualityNet provides program updates, not *Hospital Compare*. Visit the QualityNet website and select the "Join ListServes" box on the left side of the homepage to "Sign up for Notifications and Discussions." This link will direct you to the "ListServe Registration" page; choose the programs for which you want to receive notifications. These notifications will provide dates and information on public reporting, preview reports and associated program reference guides, new releases associated with each program, and application or initiative alerts.

TAHOE FOREST HEALTH SYSTEM

Origination Date:	*01/1990*
Last Approved:	*11/2017*
Last Revised:	*11/2017*
Next Review:	*11/2020*
Department:	*Governance - AGOV*
Applies To:	*System*

Patient/Family Complaints/Grievance, AGOV-24

PURPOSE:

Tahoe Forest Health System recognizes the right of every patient, and their representative to communicate their concerns or complaints regarding any aspect of the patient's care and treatment provided throughout the Tahoe Forest Health System. The purpose of this policy is to establish a system-wide approach to address patient and patient representatives' oral and written complaints, and resolve grievances in a timely and appropriate manner and in compliance and accordance with all Federal and State laws and regulations.

POLICY:

A. TFHS encourages open communication and views the resolution of complaints and grievances as an opportunity to promote service excellence while enhancing quality of care and patient safety.
   1. If the complaint involves a member(s) of the Medical Staff, the Patient Experience Specialist, Director of Quality & Regulations, or the Risk Manager will notify the Medical Director over the appropriate service where the complaint was generated of the complaint utilizing the tfhd.com electronic mail.
   2. If the complaint involves a specific hospital department, the Patient Experience Specialist, Director of Quality & Regulations, or the Risk Manager will notify the Department Director/Manager and enter into Quantros for tracking and follow up with the complainant and appropriate leaders and providers involved.

B. All complaints and grievances made by patients or patient representatives shall be investigated and resolved in a timely manner.
   1. Written complaints addressed to any or all of the Board of Directors or the Health System Administration shall be forwarded by the Executive Assistant, to the Patient Experience Specialist and the Director of Quality and Regulations in a timely manner. Copies of complaint resolution correspondence to the patient or patient representative shall be provided to the Chair of the Board or to Administration, as applicable to whom the complaint was addressed.
   2. All staff members are responsible for taking complaints and grievances when offered by a patient or patient representative. Staff members shall resolve or direct the complaints or grievances as identified in this policy.

C. The patient, and/or their representative, shall be informed of the TFHS complaint process, including how to file a formal grievance, time frames for resolving the grievance, the contact number and address for lodging a grievance with the State agency if the complaint relating to quality of care, abuse or neglect, or the provision of service is not resolved at the time it is received.

D. The Board of Directors delegates the Complaint and Grievance process to the Medical Staff Quality Committee. The Director of Quality & Regulations shall have oversight of the grievance process to review and resolve grievances in a timely and appropriate manner. A formal Grievance Committee exists to oversee that the resolution process is occurring and timely, and to participate in the final determination of appealed decisions.

E. Aggregation and analysis of data will be presented to the Medical Staff Quality Committee for review and recommendations

F. Department specific policies based upon other federal and/or state regulations unique to that department or service (i.e. extended care center, hospice) take precedence over this policy to the extent necessary to meet stricter requirements.

DEFINITIONS:

A. **Patient Complaint**: A **verbal** expression of displeasure with a process or person and verbal communication of dissatisfaction with services/outcomes or systems.

As published by the Center for Medicare and Medicaid Services (CMS) in the Conditions of Participation (CoP), §482.13(a)(2), a patient complaint is defined as the following:

1. A post-hospital verbal communication regarding patient care that would routinely have been handled by staff present if the communication had occurred during the stay/visit is not required to be defined as a grievance.
2. Billing issues are usually considered a complaint. Should a billing issue also involve a post-hospital verbal complaint regarding patient care that would routinely have been handled by staff present if the communication had occurred during the stay/visit are not required to be defined as a grievance.

B. **Patient Grievance**:
As published by the Center for Medicare and Medicaid Services (CMS) in the Conditions of Participation (CoP), §482.13(a)(2), a patient grievance is defined as the following:

1. A written or verbal complaint (when the verbal complaint is not resolved at the time of the complaint by staff present) by a patient or the patient's representative regarding the patient's care, abuse or neglect, issues related to the hospital's compliance with the CMS Hospital COPs, or a Medicare beneficiary billing complaint related to rights and limitations provided by 42 CFR §489.
2. A written complaint, including an email or faxed document, by a patient, or the patient's representative, (whether inpatient, outpatient, or released/discharged) regarding the patient's care, abuse or neglect, patient harm, and issues related to the hospital's compliance with the CMS CoP or a Medicare beneficiary billing complaint related to rights and limitations. A written complaint is always considered a grievance, as long as the concern expressed in the grievance concerns one of the three areas constituting a grievance (i.e., the care provided to the patient, abuse or neglect, or the Hospital's compliance with the COPs).

C. **Complaint vs. Grievance**

1. **Verbal Patient Care Complaint**: A verbal patient care complaint shall be considered a grievance if the issue cannot be resolved by staff present at the time the complaint is presented, if the complaint is postponed for later resolution, or if the complaint requires further investigation or action for resolution.
2. **Complaint on Satisfaction Survey**: If an identifiable patient writes or attaches a written complaint to a satisfaction or experience survey, then the complaint meets the definition of a grievance.

3. **Billing Issues:** If a billing issue also involves a post-hospital oral or written complaint regarding patient care then it shall be considered a grievance.

D. **Staff Present:** Includes any hospital staff present at the time of the complaint or who can quickly be at the patient's location (i.e. administration, management team, nursing, ancillary, house supervisors, patient advocate, case manager, quality personnel, etc.) to resolve the patient's complaint.

E. **Grievance Committee**: The Grievance Committee consists of representatives from Quality & Regulations, Risk Management, Revenue Cycle, and others as deemed necessary to evaluate and resolve grievances. The Committee meets at least quarterly to evaluate the management of the complaint process, review the aggregate data, analyze findings, and make recommendations for process improvement. Reports are submitted to the Board of Directors through the Medical Staff Quality Committee.
If a grievance determination is appealed, the Grievance Committee shall be convened to evaluate and resolve the specific grievance. Additional participants will include the Chief Executive Officer or designee, the Department Director(s) involved with the grievance issue, and representative(s) from the Medical Staff, when necessary.

F. **Complaint Acknowledgement**: A written notice to the patient and/or their representative that their concern or complaint has been acknowledged, and that an investigation has been initiated, including the expected time frame for completion.

G. **Grievance Determination**: A written notice containing the organization's outcome (i.e. determination) following review and investigation.

H. **Complaint/Grievance Resolution**: Complaints and grievances are considered resolved when the patient and/or their representative are satisfied with the actions taken by the Health System and carried out on their behalf.

TFHS may consider a complaint or grievance closed, though the patient and/or their representative remains unsatisfied with the actions taken, when the Grievance Committee determines that appropriate and reasonable actions have been conducted. In these circumstances, the Grievance Committee has been delegated by the Board of Directors to deem the grievance resolved even though the complainant is not satisfied with the outcome.

PROCEDURE:

A. **Complaints Received**

1. Staff shall receive, respond, refer, and document complaints and grievances as outlined in the Complaint Process FLOW CHART *(Ctrl+click on the link to open)*.
    a. For written complaints addressed to any or all members of the Board of Directors, or to Administration, copies of complaint resolution correspondence shall be provided to the Chair of the Board or the Administration, respectively.
2. Examples of Types of Complaints
    a. Billing (e.g. billed for service not provided, bill too high compared to other care providers, medications or supplies not given, etc.)
    b. Quality of Care (e.g. missed diagnosis, unnecessary medical test, insufficient medical testing, etc.)
    c. Service related (e.g. delay of service, negative attitude of provider, environmental service issue,

etc.)

3. See Patient and Customer Service Recovery Policy AGOV-23 regarding use of service recovery methods to resolve individual occurrences of dissatisfaction related to service.

B. **Complaint Log**

1. The Patient Experience Specialist in the Quality & Regulations Department will manage the complaint and grievance process by using the electronic FEEDBACK software in the Reporting System. This software is a tool which facilitates documentation of all complaints which cannot be immediately resolved when received. In addition, all investigation, findings, and resolution efforts are also documented in FEEDBACK. The Complaint Log consists of the aggregate of Reporting System FEEDBACK tickets.
2. Submitting a complaint in the **Reporting System FEEDBACK**:
   a. TFHS Intranet
   b. Click on the Quantros icon
   c. Select appropriate facility
   d. Click on the **Feedback** box, and
   e. Document grievance, including communications and resolution efforts.

Questions & Assistance: Contact Patient Experience Specialist ext. 6567

C. **Investigation**

1. Directors/ Managers/Supervisors may use the Complaint Investigation Template as a guide to investigate and document complaints.

D. **Process Improvements**

1. Department Directors or their designee shall be responsible for the oversight and implementation of process improvement initiatives triggered by patient complaints or grievances pertaining to their department. Management of system-wide process improvement will be facilitated by the Quality & Regulations Department.
2. Department Directors or their designee shall be responsible to provide data and reports on process improvement initiatives to the Quality & Regulations Department. Analysis and reporting of complaints will be provided to appropriate medical staff committees, and Medical Staff Quality Committee, and the Board of Directors.
3. Complaint and Grievance Process Confidentiality

   Personnel, department directors, and committees charged with complaint investigations, findings, recommendations, and reports pursuant to this policy shall be considered to be acting on behalf of TFHS Medical Staff and Board of Directors, and thus shall be deemed to be "professional review bodies" as that term is defined by the Healthcare Quality Improvement Act of 1986.

Related Policies/Forms: Patient and Customer Service Recovery Policy AGOV-23; Complaint-Grievance Process DHOS-1010 *Complaint Process FLOW CHART* (attached)*; Complaint Investigation Template*
References: Center for Medicare and Medicaid Services (CMS), 2005 Conditions of Participation, §482.13(a)(2); *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2011-Transmittals-Items/CMS1255066.html*; American Osteopathic Association, 2008 Healthcare

Facilities Accreditation Program
Policy Owner: Director, Quality & Regulations
Approved by: Chief Operating Officer

All revision dates: 11/2017, 08/2015, 04/2014, 11/2013, 12/2012, 03/2012, 02/2009

Attachments:

Complaints Grievances FLOW CHART.docx

Image 01

Approval Signatures

Step Description	Approver	Date
	Harry Weis: CEO	11/2017
	Sarah Jackson: Executive Assistant	11/2017

Applicability

Tahoe Forest Hospital District

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

CMS RURAL HEALTH STRATEGY

Summary

To inform the development of a strategic plan to improve health care in rural America, the Centers for Medicare & Medicaid Services (CMS) Rural Health Council sought input on the challenges and local solutions associated with providing high quality health care in rural communities through a series of listening sessions with rural stakeholders and consumers. The result has led to the identification and resolution of several specific health care provider issues, better understanding of the impact of CMS policies on providers, and a rural health strategy that focuses on five objectives:

1. Apply a rural lens to CMS programs and policies
2. Improve access to care through provider engagement and support
3. Advance telehealth and telemedicine
4. Empower patients in rural communities to make decisions about their health care
5. Leverage partnerships to achieve the goals of the CMS Rural Health Strategy

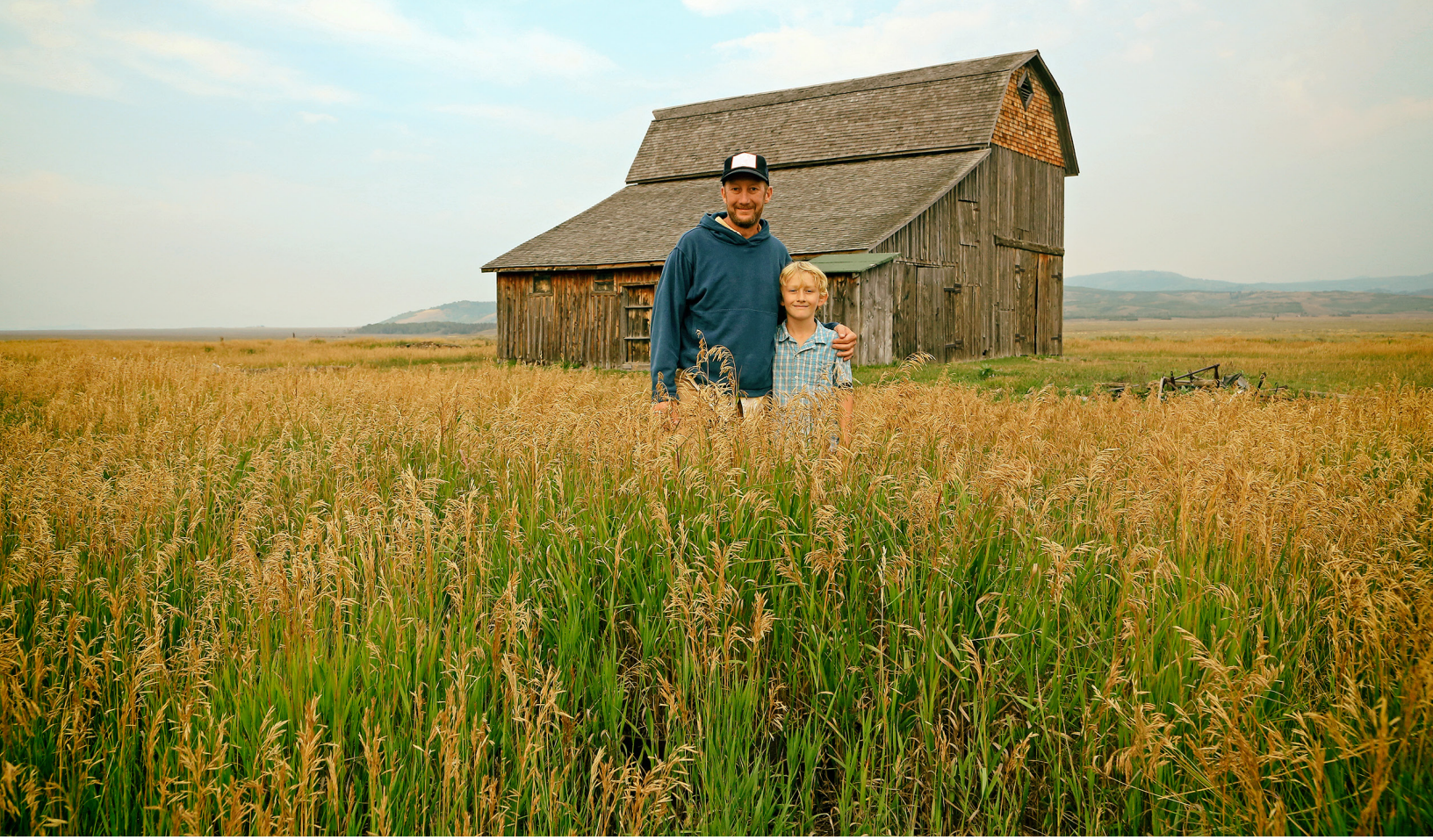
The strategy supports CMS' overall effort to reduce provider burden, and aligns with other CMS priorities, such as improving quality of care and tackling the opioid epidemic. Through the implementation of the CMS Rural Health Strategy and continued stakeholder engagement, we will aim to promote policies that help make health care in rural America accessible, affordable, and accountable.

Background

Approximately 60 million people live in rural areas across the United States[1], including millions of Medicare and Medicaid beneficiaries.[2] Although not as diverse as their urban counterparts, rural communities are becoming more diverse, driven in large part by growth among populations not historically represented in large numbers such as Asian Americans.[3] Compared to their urban counterparts, rural Americans are more likely to be living in poverty, unhealthy, older, uninsured or underinsured, and medically underserved.[4] Additional challenges facing rural America include a fragmented health care delivery system, stretched and diminishing rural health workforce, affordability of insurance, and lack of access to specialty services and providers.

The CMS Rural Health Council (RH Council) consists of experts from across the Agency, and its mission is to sustain a proactive and strategic focus on health and health care issues across rural America by shaping CMS regulations and policies and making long-term recommendations that positively impact rural health consumers, providers, and markets. Since its inception in 2016, the RH Council has focused on three strategic areas:

1. **Ensuring access to high-quality health care to all Americans in rural settings.** This includes maintaining the security of health insurance coverage and accessibility of health insurance options provided under CMS' programs, and giving people the tools they need to seek the best care for themselves and their families.
2. **Addressing the unique economics of providing health care in rural America.** This includes monitoring health care market impacts in rural areas; advising CMS on payments related to health care services furnished in rural areas; reducing regulations and requirements that affect rural areas, where possible; and encouraging rural stakeholders to participate in the rulemaking process.
3. **Bringing the rural health care focus to CMS' health care delivery and payment reform initiatives.** This includes engaging stakeholders and rural health care providers on delivery system reform and innovation opportunities.



CMS created the Rural Health Strategy to organize and promote work in the above focus areas. To develop the CMS Rural Health Strategy, the RH Council began by identifying current activities focused on rural providers and communities, understanding how each of the CMS Centers and Offices incorporates rural issues when developing policies and programs, and engaging with rural stakeholders to understand their challenges. The RH Council also held a series of listening sessions at conferences, the CMS Rural Solutions Summit, and regional listening sessions to learn from a broad array of stakeholders, including rural beneficiaries about local solutions and the challenges to implementing the solutions. Specifically, the RH Council sought to understand the current state of health care and related services in rural America; the challenges to having accessible, affordable, and accountable health care in rural areas; and potential solutions to address the identified challenges.

The feedback and information collected from stakeholders was analyzed and summarized into eight themes:

1. Improving Reimbursement
2. Adapting and Improving Quality Measures and Reporting
3. Improving Access to Services and Providers
4. Improving Service Delivery and Payment Models
5. Engaging Consumers
6. Recruiting, Training, and Retaining the Workforce
7. Leveraging Partnerships/Resources
8. Improving Affordability and Accessibility of Insurance Options

Rural Health Strategy

Informed by the findings of the listening sessions, the RH Council focused on the challenges that CMS could help address while developing the CMS Rural Health Strategy. The purpose of the CMS Rural Health Strategy is to inform CMS' work, as it relates to rural health, and thereby help CMS achieve its vision for equitable rural health and health care. The strategy applies a rural lens to new and ongoing activities of the Agency and informs the pathway by which CMS can achieve its rural health vision through intra-agency collaboration, stakeholder engagement, and the elevation of programs and policies that will advance the state of rural health care in America. The CMS Rural Health Strategy is also intended to align with overarching HHS and CMS strategies, like burden reduction and empowering patients and providers to make decisions about their health care. The CMS Rural Health Strategy identifies five specific objectives and supporting activities to help the Agency achieve its vision for rural health. The RH Council will also collaborate in the implementation of the Agency's overall opioid strategy, given the disproportionate impact the epidemic is having on rural communities, as well as with the clinician engagement activities. Moreover, the RH Council will continue to engage stakeholders and share feedback to support the other relevant CMS activities related to rural health that are not mentioned explicitly in this strategy.

Objectives:

1. Apply a Rural Lens to CMS Programs and Policies

Understanding that CMS' policies and programs may uniquely impact rural and other vulnerable populations, CMS recognizes the need to consider policymaking, program design, and strategic planning through a rural lens to promote health equity among all populations that CMS serves. CMS has already taken steps to integrate consistent consideration of the rural health impact of policies under review. By optimizing its policy review and development for health equity, CMS will work to identify areas where it can better meet the needs of vulnerable populations, and avoid unintended negative consequences of policy and program implementation for vulnerable populations and communities.

Key Supporting Activities

- Utilize the "Optimizing CMS Policies and Programs for Health Equity Checklist" to review relevant policies, procedures, and initiatives for possible impacts on rural health insurance plans, providers, or communities.

- Identify and accelerate diffusion of promising, evidence-based practices to improve access to services and providers in rural communities. Integrate a rural health lens into quality improvement and innovation activities (e.g., the Quality Improvement Networks/Quality Improvement Organizations Program, Hospital Improvement Innovation Network Rural Hospital Affinity Group, Medicaid Innovation Accelerator Program, Health Care Payment Learning and Action Network).

2. Improve Access to Care Through Provider Engagement and Support

Rural providers and patients alike have challenges providing and accessing services in rural areas due to a range of barriers that include, but are not limited to, the lack of providers and specialists, difficulty recruiting and retaining health care providers across all levels of care, and limited capacity among clinical and administrative staff. In response to these barriers, the second CMS rural health strategic objective is to improve access to care through provider engagement and support. This objective focuses on maximizing provider scope of practice; providing technical assistance to providers to ensure that they can fully participate in CMS programs; and identifying new ways to overcome patient barriers to access, such as a lack of transportation.

Key Supporting Activities

- **Scope of Practice:**
  Explore options to increase the number of trained and licensed allied health professionals able to provide health care in rural communities. Options could include evaluating eligibility for certain provider types to practice up to the limit of their licensure to expand the range of providers in

rural areas eligible for payment (e.g., Chronic Care Management; types of providers include Nurse Practitioners, Physician Assistants, and Certified Registered Nurse Anesthetists).

- **Meaningful Measures:**
  Implement a new approach to quality measurement that focuses on value rather than volume, thereby reducing reporting burden, particularly for rural providers.

  Review and revise current quality measures across CMS programs to ensure that measure sets are streamlined, outcomes-based, and meaningful to rural providers and patients.

  Align quality measurement activities with other industry measurement initiatives such as National Quality Forum efforts around rural health and telemedicine to improve quality measurement for rural providers.

- **Technical Assistance:**
  Provide technical assistance to providers to help them comply with policies, and implement CMS policies and initiatives to develop or transform their practice (e.g., Transforming Clinical Practice Initiative, Quality Payment Program, clarifying provider understanding of conditions of participation).

  Provide technical assistance on quality measure reporting to rural providers in support of quality improvement.

  Leverage CMS contractors and others (e.g., Medicare Administrative Contractors, Quality Improvement Organizations, State Survey Agencies and entities with deeming authority) to foster quality improvement efforts by rural providers through the submission of quality measures, data analysis, and provider engagement and outreach.

- **Transportation:**
  Explore opportunities within existing Center for Medicare and Medicaid Innovation fraud and abuse waivers that could cover certain transportation services.

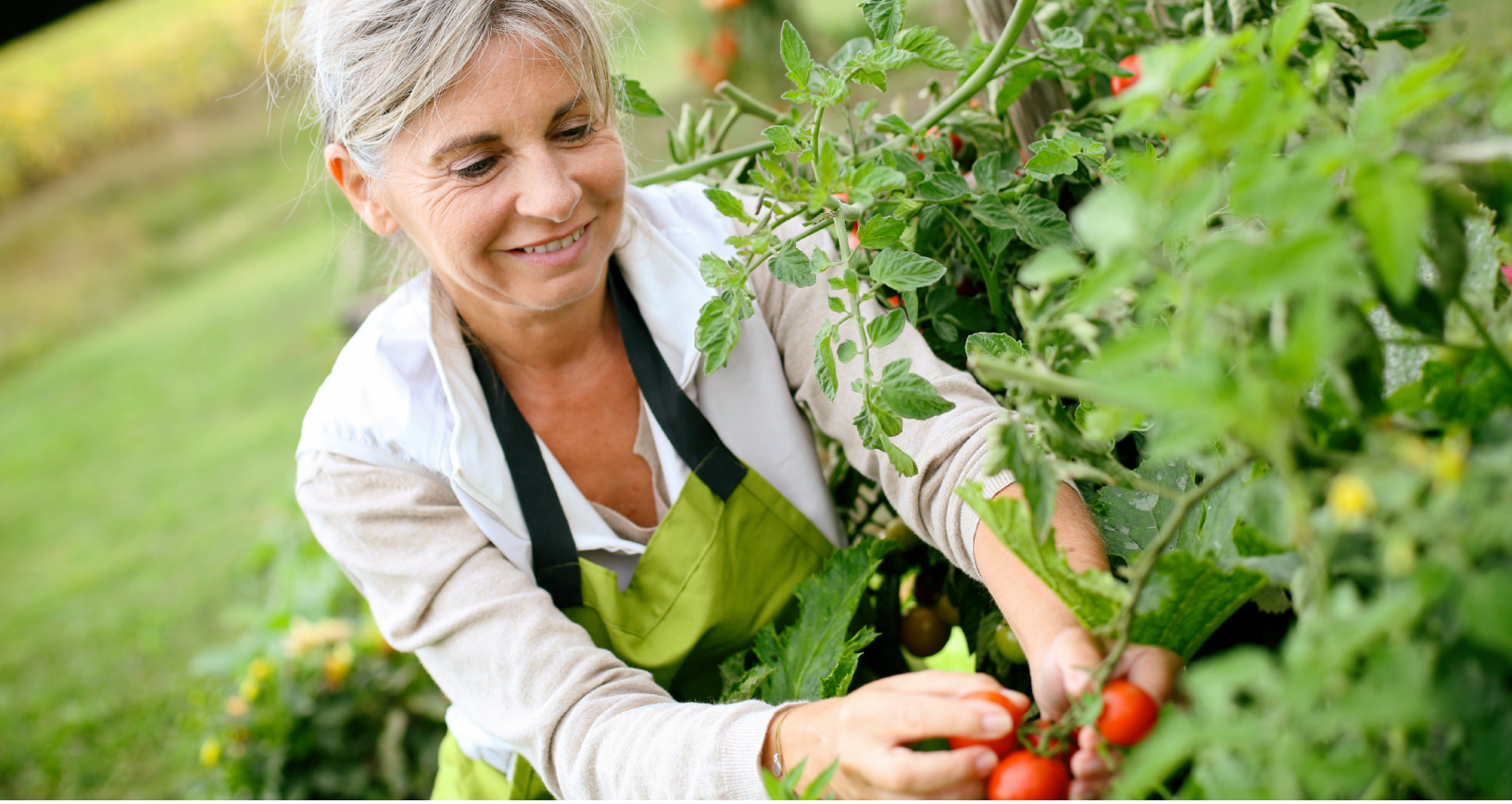
  Include transportation and telehealth flexibilities within new Center for Medicare and Medicaid Innovation models where appropriate.

3. Advance Telehealth and Telemedicine

Telehealth has been identified as a promising solution to meet some of the needs of rural and underserved areas that lack sufficient health care services, including specialty care,[5, 6] and has been shown to improve access to needed care, increase the quality of care, and reduce costs by reducing readmissions and unnecessary emergency-department visits.[7] To promote the use of telehealth, CMS will seek to reduce some of the barriers to telehealth use that stakeholders identified in the listening sessions, such as reimbursement, cross-state licensure issues, and the administrative and financial burden to implement telemedicine.

Key Supporting Activities

- Explore options for modernizing and expanding telehealth through Center for Medicare and Medicaid Innovation models and demonstrations, such as the Next Generation Accountable Care Organization Model, Frontier Community Health Integration Project Demonstration, and Bundled Payments for Care Initiative advanced model.



4. Empower Patients in Rural Communities to Make Decisions About Their Health Care

Like many patients, rural populations have difficulty understanding their health insurance coverage and navigating the health care system to get the care they need. Rural communities tend to have unique challenges, such as limited access to specialty providers and longer distances to travel for medical care. These barriers accentuate the need to ensure information is reaching rural patients so that CMS can best support and empower them to make decisions about their health care. Understanding that rural communities may need different communication and outreach approaches than their urban and suburban counterparts, CMS will explore different ways to engage rural populations. Patient and family engagement is an essential part of fostering responsibility and partnership in a person's health care, so CMS will leverage existing rural communication networks to empower patients and families with the information and tools they need to be actively engaged in their health care and strengthen their patient-provider relationships.

Key Supporting Activities

- Collaborate with rural communication networks to develop and disseminate easy-to-understand materials to help rural patients navigate the health care system.
- Foster the empowerment and engagement of rural patients in their health care through targeted outreach efforts.

5. Leverage Partnerships to Achieve the Goals of the CMS Rural Health Strategy

Finally, because the health care challenges experienced by rural communities in America cannot be solved by CMS alone, a key objective of the CMS Rural Health Strategy is to leverage partnerships with stakeholders, at multiple levels, to achieve the stated goals. This objective recognizes the importance of collaborative partnerships, both on the federal level and at the regional, state, and local levels. The approach is intended to create a climate of collaboration, collective information, and joint action among CMS and its partners. Additionally, leveraging partnerships will support a smooth, effective, and inclusive implementation of the CMS Rural Health Strategy, extending the dialogue initiated by the listening sessions to provide opportunities for reflection on important milestones as well as an understanding of the rural health community's role in success.

Key Supporting Activities

- Explore opportunities with the Office of the National Coordinator for Health Information Technology and other federal partners to promote interoperability and increase utilization of electronic health records for quality improvement in rural areas.
- Work with federal and state partners such as the Federal Office of Rural Health Policy, to understand and evaluate the impacts of CMS programs on rural communities, and develop recommendations as appropriate.
- Convene CMS and health plan representatives to discuss challenges and strategies to increase participation of health plans in rural areas.
- In coordination with the Centers for Disease Control and Prevention and other federal partners, increase the focus on maternal health, behavioral health, substance use disorders, and the integration of behavioral health and primary care.

Through the implementation of this strategy, CMS and its partners will help make health care in rural America accessible, accountable, and affordable – resulting in the highest quality of care.

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1. United States Census Bureau. 2010 Census Urban and Rural Classification and Urban Area Criteria. Available at: http://www.census.gov/geo/www/ua/2010urbanruralclass.html.
2. Centers for Medicare & Medicaid Services, Office of Enterprise Data and Analytics, Chronic Conditions Data Warehouse; United States Census Bureau.
3. Housing Assistance Council. Race & ethnicity in rural America. Washington, DC: Housing Assistance Council; 2012. Available from: http://www.ruralhome.org/storage/research_notes/rrn-race-and-ethnicity-web.pdf.
4. Medicare Payment Advisory Commission (MedPAC 2012). "Report to Congress: Medicare and the Health Care Delivery System." Washington, DC: Medicare Payment Advisory Commission, June 2012.
5. Health Services and Resources Administration Federal Office of Rural Health Policy (2015). Available at: https://www.hrsa.gov/ruralhealth/telehealth/index.html.
6. Health Services and Resources Administration Federal Office of Rural Health Policy (2015). Available at: https://www.hrsa.gov/ruralhealth/telehealth/index.html.
7. IOM (Institute of Medicine). 2012. The role of telehealth in an evolving health care environment: Workshop summary. Washington, D.C.: The National Academies Press.

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