TAHOE FOREST HOSPITAL DISTRICT

2025-02-10 Board Quality Committee Meeting

Monday, February 10, 2025 at 12:00 p.m.

Eskridge Conference Room - Tahoe Forest Hospital

10121 Pine Avenue, Truckee, CA 96161

Meeting Book - 2025-02-10 Board Quality Committee Meeting

TAHOE FOREST
HOSPITAL DISTRICT

QUALITY COMMITTEE
AGENDA

Monday, February 10, 2025 at 12:00 p.m.
Eskridge Conference Room – Tahoe Forest Hospital
10121 Pine Avenue, Truckee, CA 96161

1. CALL TO ORDER

2. ROLL CALL
Alyce Wong, Chair; Rob Darzynkiewicz, MD, 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: 11/22/2024 ..... ATTACHMENT

6. CLOSED SESSION

6.1. Hearing (Health & Safety Code § 32155)
Subject Matter: Case Review
Number of items: One (1)

6.2. Hearing (Health & Safety Code § 32155)
Subject Matter: Board Quality Dashboard Review

6.3. Approval of Closed Session Minutes
6.3.1. 11/22/2024 Closed Session Board Quality Committee

7. ITEMS FOR COMMITTEE DISCUSSION AND/OR RECOMMENDATION

7.1. Informational Reports

7.1.1. Patient & Family Centered Care

7.1.1.1. Patient & Family Advisory Council (PFAC) Update..... ATTACHMENT
Quality Committee will receive an update related to the activities of the Patient and Family Advisory Council (PFAC).

7.1.2. Patient Safety

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

7.2. Safety First

7.3. Quality Assessment Performance Improvement (AQPI-05)…….ATTACHMENT

Review the QA PI Plan and attachments and provide input on the 2025 priorities.

7.4. CAH National Patient Safety Goals…….ATTACHMENT
Review the National Patient Safety Goals and provide an update on the strategies to address each goal at TFHD.

7.5. Process Improvement Projects
An update will be provided regarding the Vizient project plan, Management Systems, and future process improvement activities.

7.6. Board Quality Education .....ATTACHMENT
The Committee will review the educational article listed below and discuss topics for future board quality education.
Centers for Medicare & Medicaid Services, *The CMS Framework for Health Equity (2022-2032)* (2022).

8. REVIEW FOLLOW UP ITEMS / BOARD MEETING RECOMMENDATIONS

9. NEXT MEETING DATE
The next committee date and time will be confirmed for May 2025.

10. 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 582-3583 at least 24 hours in advance of the meeting.

TAHOE FOREST HOSPITAL DISTRICT

QUALITY COMMITTEE
DRAFT MINUTES

Friday, November 22, 2024 at 12:00 p.m.
Eskridge Conference Room – Tahoe Forest Hospital
10121 Pine Avenue, Truckee, CA 96161

1. CALL TO ORDER
Meeting was called to order at 12:01 p.m.

2. ROLL CALL
Board: Michael McGarry, Chair; Robert Barnett, Board Member
Staff in attendance: Crystal Felix, Chief Financial Officer; Dr. Brian Evans, Chief Medical Officer; Jan Iida, Chief Nursing Officer; Janet Van Gelder, Director of Quality & Regulations; Maggie Abrams, Skilled Nursing Facility Director of Nursing; Christine O'Farrell, Risk Manager; Dorothy Piper, Director of Medical Staff Services; Martina Rochefort, Clerk of the Board

3. CLEAR THE AGENDA/ITEMS NOT ON THE POSTED AGENDA
No changes were made to the agenda.

4. INPUT – AUDIENCE
Dr. Brian Evans, Chief Medical Officer, complimented the board presentation on the CMS 5-Star Rating.

5. APPROVAL OF MINUTES OF: 08/06/2024
Director Barnett moved to approve the Board Quality Committee Minutes of August 6, 2024, seconded by Director McGarry.

Open Session recessed at 12:04 p.m.

6. CLOSED SESSION
6.1. Hearing (Health & Safety Code § 32155)
Subject Matter: Case Review
Number of items: One (1)
Discussion was held on a privileged item.

6.2. Approval of Closed Session Minutes
6.2.1. 08/06/2024 Closed Session Board Quality Committee
Discussion was held on a privileged item.

Open Session reconvened at 12:21 p.m.

7. ITEMS FOR COMMITTEE DISCUSSION AND/OR RECOMMENDATION
7.1. Informational Reports
7.1.1. Patient & Family Centered Care
7.1.1.1. Patient & Family Advisory Council (PFAC) Update

Quality Committee received an update related to the activities of the Patient and Family Advisory Council (PFAC).

CMS has introduced a new Patient Safety Structural Measure (PSSM) for 2025 that recommended a board member sit on PFAC. Director Barnett would like to join PFAC after his board seat ends.

7.1.2. Patient Safety

7.1.2.1. BETA HEART Program Progress Report

No discussion was held.

7.2. Safety First

CMO shared a Safety First about the single elevator being out in the Medical Office Building and the accommodations.

Dr. Mieka Conway, Medical Director of Quality, joined the meeting at 12:30 p.m.

Janet Van Gelder, Director of Quality & Regulations, shared community feedback.

7.3. Standard Work Bundles

Quality Committee reviewed the standard work bundle data and process improvement activities to date.

The standard work bundles are part of the star rating. Quality is collecting this data.

Director of Quality asked how the Board would like this information shared.

7.4. Process Improvement Projects

The Board of Directors received an in-depth update on the Vizient project plan, Management Systems, and future process improvement activities at the Board of Directors meeting last night.

CMO added there will be six candidates interviewing for the Director of Process Improvement.

CFO shared there will be people to carry the process forward learned from Vizient. Currently, the projects is starting visual management and GEMBAs. There are still some items for Vizient to train this organization on.

CFO's team in the Access Center that has done the work in management systems is so much more engaged now.

Discussion was held on the impact of the management systems work.

A lot of the growth on clinic visits were from those being seen in private practice. There will be pressure from secondary service area.

7.5. Board Quality Education

Quality Committee reviewed the educational articles listed below and discuss topics for future board quality education:

7.5.1. Hall, WJ, Chapman, MV, Lee, KM, Merino, YM, Thomas, TW, Payne, BK, Eng. E, Day, SH, Coyne-Beasley, T. *Implicit Racial/Ethnic Bias Among Health Care Professionals and Its Influence on Health Care Outcomes: A Systematic Review.* American Journal of Public Health, 105, 12 (2015).

Director McGarry shared a story about implicit bias.

Harvard has a website where people can take bias tests. It is typical for people to have bias based on the way they have grown up.

Biases are hard to erase.

Director McGarry inquired if it is possible that its affecting the quality of care. People may make snap judgments on social class etc. CMO wants to get away from immediate judgement. CMO did a journal club on this topic. We have not invested in a big project on this topic.

Director of Quality noted the Health System has not received complaints on this item.

Director Barnett shared information on jury bias and a study on how people's biases affect outcomes. Everyone has bias. Bias is getting to a decision fast without a lot of data.

Director McGarry asked if is it possible to have institutional level bias. Would there be someone out there that would not choose Tahoe Forest because of bias?

Dr. Conway felt yes there could be. Our Press Ganey scores on diversity are lower. Director of Quality & Regulations noted this could be asked of the PFAC group. Dr. Conway would be happy to be part of that conversation.

8. REVIEW FOLLOW UP ITEMS / BOARD MEETING RECOMMENDATIONS
No discussion was held.

9. NEXT MEETING DATE
The next committee date and time will be confirmed for February 2025.

10. ADJOURN
Meeting adjourned at 1:21 p.m.

Patient and Family Advisory Council (PFAC) Summary Report

January 2024 – January 2025

Alix Crone, DC, CPXP – Clinical Patient Experience Specialist

Summary of Monthly Topics

January 2025 – Christine O'Farrell, Risk Manager/Patient Safety Associate, presented a case review/analysis in which a medical error occurred. The case involved an ICU nurse who inadvertently administered IV insulin to a patient instead of a different medication. The error was immediately identified and intervention began promptly, resulting in no harm or symptoms to the patient. There was discussion about the event analysis process, including the disclosure to patient and family members, identifying contributing factors, and the action plan to prevent similar situations from happening again.

January 2024 – Kat Sigafoose, Director of Patient Access, discussed our current customer service training/expectations of our registration staff and identified improvement opportunities through a "Secret Shopper" program. We elicited input from the PFAC with regard to evaluation criteria and process for implementation. Emphasized that positive experienced should be shared/reinforced with the involved staff to help incentivize. Discussed a proposed "Disruptive Patient" agreement and policy that has come about in response to increased incidents of disruptive and aggressive patients. Proposed new messaging/wording of signs displayed to notify patients of behavior expectations. Suggested de-escalation training for all staff to be considered as a requirement.

February – Jonathan Lowe, NP, a Behavioral Health provider, presented on Spravato (aka esketamine) treatment for chronic depression. This is the first FDA-approved psychedelic treatment, though the Covid pandemic halted/slowed its use. It is used primarily for treatment-resistant depression and so far over 750 treatments have been administered at TFH with a very high patient-reported success rate. Currently limited due to lack of a "buy and bill" system which would allow us to collect better reimbursement and cut out the need for using specialized pharmacies in other states outside of our health system. Jonathan discussed other current needs for our community to include more therapists, more space and expanded services, such as group therapy.

March – Heather Hiller, Clinical Quality Analyst, presented about the prevalence and warning signs of sepsis, and elicited input from PFAC with regard to spreading community education/awareness. Sepsis is the leading cause of death in US hospitals as well as the leading cause of hospital readmissions. TFH has implemented sepsis "bundles" that are utilized for initial intervention. TFH also initiated a Multidisciplinary Sepsis Committee 2 years ago, performs sepsis drills, and identifies awards for staff with great recognition/care for sepsis on a quarterly basis. We are well above the National and State compliance rate benchmarks for our CMS Core Measure that tracks Severe Sepsis/Septic Shock at 92.3% as of last year. Ideas on improving education/awareness through our local news outlets (Moonshine Ink), links to videos online, education through the Rec Center during "Golden Hour" sessions, and on our internet page or collaboration with our Marketing Department.

April – Alix Crone, Clinical Patient Experience Specialist, reviewed our current Patient Satisfaction scores from Press Ganey for our main service lines. We discussed the survey process and reviewed the questions asked on the surveys. We looked for potential factors and explanations into trends and changes occurring over the last couple of years to current. We discussed how scores and comments were shared with leadership, and improvement opportunities stemming from the feedback. One member recommended exploring use of ChatGPT to help organize feedback and identify immediate trends/themes within.

May – Ellie Cruz, Manager of Labor and Delivery, will be presenting on possible community labor doula services at Tahoe Forest. She educated on the positive clinical outcomes associated with the utilization of doulas, and seeking buy-in for a doula program. The primary objective and goal is to obtain a registry of volunteers to serve as hospital doulas. TFH would cover the training classes for free in exchange for their volunteer hours. Ellie was seeking input from PFAC on how to spread the word within the community to gather interest.

June – Meg Rab, Director of Marketing and Advertising, along with Ted Owens, Executive Director of Governance and Business Development, came to gather input on general marketing and advertising ideas for the near and distant future. Presented new initiatives and re-allocation of funds currently in place. The overarching goal is to re-engage our community. The PFAC members were able to provide feedback on the current branding/perception within the community, from which to help guide the messaging and mode of communication. We also presented suggestions for boosting our service lines where we do have more capacity (Urgent Care, Emergency Department), as there is concern that additional marketing/advertising to the outside would further inhibit access to care for the local population. Marketing will return this fall for additional updates on the current website.

September – Dylan Crosby, VP of Facilities and Construction, updated the group on future construction projects at Tahoe Forest. The primary objective of these projects is to improve patient access to care, by expanding both the capacity for service lines with physical space, as well as improving efficiency. The Patient and Family Advisory Council were the first "public" community members to have been updated on proposed projects. The primary areas discussed were plans for the former Rite Aid building, the Gateway building, and the Tahoe City clinics on Fabian Way.

October – Ted Owens, Executive Director of Governance and Business Development, and Meg Rab, Director of Marketing and Advertising, returned to provide some updates to the group on current projects and media campaigns. Ted presented on two seismic bills that recently went through the CA legislature, one of which was approved and one of which was denied. He informed the group of the potential impacts on TFH with regard to proposed legislation. Meg presented new media campaigns, to include a video that was produced to celebrate TFH'S 75th anniversary, as well as eNewsletters for various service lines, and plans for the TFHD website. User engagement via social media has improved significantly over the last year and this will continue to be a focus for outreach to the community.

November – Maggie Abrams, Director of Distinct Part Skilled Nursing Facility, introduced Tahoe Forest's SNF/ECC, outlined the process for admission, and current/future projects to improve the facility for resident safety and comfort. Our Distinct Part SNF is a 37 bed facility with 3 levels of care: Rehab/skilled nursing, long term/custodial care, and hospice/end of life care. 2 current projects are regarding fall prevention and an electronic medical record system. The SNF utilizes EPIC, TFH's EMR system, for prescriptions only, but is otherwise on its own EMR system that does not communicate with EPIC. Looking into options to streamline care for patients.

Current Overview

- Ongoing goal is to have PFAC identify ways to help educate community on all services offered by TFHS, as well as provide input and feedback on current and future processes and systems.

- Plan for 2025 is to receive updates following input/feedback. The council would like more frequent follow up from the bigger areas of concern, such as patient access/scheduling and referrals. The council would like to continue to be at the forefront of upcoming changes and plans to the health system's services offered.

- PFAC meets every month, 9 months in the year. We do not meet during the months of July, August, or

December.

- Next PFAC meeting is February 18, 2025.

Current Members and Start Date

Kevin Ward	9/20/2018	Carina Toledo	11/17/2022
Sandy Horn	9/5/2019	Cris Valerio	12/1/2022
Violet Nakayama	10/31/2019	Jane Rudolph-Bloom	1/1/2024
Alan Kern	2/20/2020	Amber Mello	5/1/2024
Kathee Hansen	4/1/2021	Sharon Strojny	6/1/2024

Beta HEART Progress Report for Year 2025

(January 2025)

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 2025:

- Beta HEART Validation Survey completed May 22, 2024: validated in all 5 domains, cost savings of $159,866.
- 2025 validation planned for April, 2025.

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: Ashley Davis, PSO & Beta HEART Lead)	Validated 2024: $31,973.20	0%	-Greater than 75% completion rate for SCOR Culture of Safety Survey -Achieve Tier 2 in Zero Harm (OB & ED)	• SCOR culture of safety survey will be administered February-March 2025. Will be full survey and all employees, clinicians, contractors, and volunteers are able to take the survey. • TFHD Women & Family Center and both Emergency Departments will be participating in Zero Harm programs again in 2025. • Plan to send 12 leaders to workshops in 2025.
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: Christine O'Farrell, Risk Manager)	Validated 2024: $31,973.20	0%	-75% or greater response time for event analyses within 45 days of event reported -75% or greater response time for closure of action items within 90 days of event reported	TFHD incorporates the transparent and timely reporting of safety events to ensure rapid change in providing safer patient care. All investigations utilize collaborative just culture and high reliability principles and encourage accountability. The Reliability Management Team reviews all action plans to address strength of action items. • Plan to send 12 leaders to workshops in 2025.
Communication and transparency: A commitment to honest and transparent communication with patients and family members after an adverse event (Lead: Christine O'Farrell, Risk Manager)	Validated 2024: $31,973.20	0%	75% or greater response time for closure of event within 60 days	• Disclosure checklist updated and refined as we update process and leaders trained to respond to events. • Risk and Safety to provide case presentation to PFAC in January 2025 to promote transparency and request feedback on action items. • Plan to send 12 leaders to workshops in 2025.
Care for the Caregiver: An organizational program that ensures support for caregivers involved in an adverse event (Lead: Stephen Hicks, Peer Support Lead)	Validated 2024: $31,973.20	0%	75% or greater response time for peer supporter deployment made in 0-12 hours	• Ongoing training and quarterly peer support and steering committee meetings. Currently have 40 peer supporters available to all staff. • 2024 average time from peer support request to deployment was 45 minutes. • Peer Support team member trained as a Mental Health First Aid trainer and will provide in-house training to staff and medical staff in 2025. • Plan to send 12 leaders to workshops in 2025.
Early Resolution: A process for early resolution when harm is deemed the result of inappropriate care or medical error (Lead: Christine O'Farrell, Risk Manager)	Validated 2024: $31,973.20	0%	75% or greater response time for closure of event within 60 days	• Plan to send 12 leaders to workshops in 2025. • 2024 average time for closure of event is 15 days.

Status **Draft** PolicyStat ID **17194995**

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

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

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

RISK:

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

POLICY:

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

MISSION STATEMENT

The mission of Tahoe Forest Health System is *"To enhance the health of our communities through*

excellence and compassion in all we do."

VISION STATEMENT

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

VALUES STATEMENT

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

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

WINNING ASPIRATIONS

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

PERFORMANCE IMPROVEMENT INITIATIVES

A. The ~~2024~~2025 performance improvement priorities are based on the principles of STEEEP™, (Safe, Timely, Effective, Efficient, Equitable, Patient Centered Care) and the Quadruple Aim:
    1. Improving the patient experience of care (including quality and satisfaction);
    2. Improving the health of populations;
    3. Reducing the per capita cost of health care;
    4. Staff engagement and joy in work.
B. Priorities identified include:

1. Exceed national benchmark with quality of care and patient satisfaction metric results with a focus on process improvement and performance excellence
    a. Striving for the Perfect Care Experience
    b. Identify and promote best practice and evidence-based medicine
    c. Focus on CMS quality star rating improvements, within the measure groups, that fall below benchmark
    d. ~~Emphasis on~~Highlight Management Systems and standard work process improvement, utilizing lean principles, to improve quality, access, and efficiency
    e. Emphasis on health equity in order to attain the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes (Health equity | CMS).

2. Continued focus on quality and patient/employee safety related to infectious diseases, following CDC, State, and County Health guidelines, and utilizing the following strategies:
    a. Strengthen the system and environment
    b. Support patient, family, and community engagement and empowerment
    c. Improve clinical care
    d. Reduce harm
    e. Boost and expand the learning system
3. Ongoing survey readiness, and compliance with federal and state regulations, resulting in a successful triennial General Acute Care Hospital Relicensing (GACHLRS) and Rural Health Clinic re-accreditation survey
4. Sustain a culture of safety, transparency, accountability, and system improvement
    a. Continued participation in Beta HEART (Healing, Empathy, Accountability, Resolution, Trust) program
    b. Conduct annual Culture of Safety SCORE (Safety, Culture, Operational, Reliability, and Engagement) survey
    c. Continued focus on the importance of event reporting, including near misses
5. Focus on our culture of safety, across the entire Health System, utilizing High Reliability Organizational thinking
    a. Proactive, not reactive
    b. Focus on building a strong, resilient system
    c. Understand vulnerabilities
    d. Recognize bias
    e. Efficient resource management

f. Evaluate system based on risk, not rules

6. Emphasis on achieving highly reliable health care through the following:
    a. A commitment to the goal of zero harm
    b. A safety culture, which ensures employees are comfortable reporting errors without fear of retaliation
    c. Incorporate highly effective process improvement tools and methodologies into our work flows
    d. Ensure that everyone is accountable for safety, quality, and patient experience
7. Support Patient and Family Centered Care and the Patient and Family Advisory Council
    a. Dignity and Respect: Health care practitioners listen to and honor patient and family perspectives and choices. Patient and family knowledge, values, beliefs and cultural backgrounds are incorporated into the planning and delivery of care.
    b. Information Sharing: Health care practitioners communicate and share complete and unbiased information with patients and families in ways that are affirming and useful. Patients and families receive timely, complete and accurate information in order to effectively participate in care and decision-making.
    c. Participation: Patients and families are encouraged and supported in participating in care and decision-making at the level they choose.
    d. Collaboration: Patients, families, health care practitioners, and health care leaders collaborate in policy and program development, implementation and evaluation; in research; in facility design; and in professional education, as well as in the delivery of care.
8. Promote lean principles to improve processes, reduce waste, and eliminate inefficiencies
9. Maximize Epic reporting functionality to improve data capture and identification of areas for improvement
10. Develop an enterprise wide data governance strategy

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

ORGANIZATION FRAMEWORK

Processes cross many departmental boundaries and performance improvement requires a planned, collaborative effort between all departments, services, and external partners, including third-party payors and other physician groups. Though the responsibilities of this plan are delineated according to common

groups, it is recognized that true process improvement and positive outcomes occur only when each individual works cooperatively and collaboratively to achieve improvement.

Governing Board

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

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

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

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

D. The Board:

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

Administrative Council

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

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

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

Board Quality Committee

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

Medical Executive Committee

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

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

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

Department Chairs of the Medical Staff

A. The Department Chairs:

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

Medical Staff

A. The Medical Staff is expected to participate and support performance improvement activities.

B. The Medical Staff provides effective mechanisms to monitor, assess, and evaluate the quality and appropriateness of patient care and the clinical performance of all individuals with delineated clinical privileges. These mechanisms are under the purview of the Medical Staff peer review process. Consistent with this process, performance improvement opportunities are addressed, and important problems in patient care or safety are identified and resolved. Annually, the Departments will determine critical indicators/performance measures consistent with strategic and performance improvement priorities and guidelines.

C. The Medical Director of Quality (Director) provides physician leadership that creates a vision and direction for clinical quality and patient safety throughout the Health System. The Director, in conjunction with the Medical Staff and Health System leaders, directs and coordinates quality, patient safety, and performance improvement initiatives to enhance the quality of care provided to our patients. The Director communicates patient safety, best practices, and process improvement activities to the Medical Staff and engages them in improvement activities. The Director chairs the Medical Staff Quality Committee.

Hospital Management (Directors, Managers, and Supervisors)

A. Management is responsible for ongoing performance improvement activities in their departments and for supporting teams chartered by the Medical Staff Quality Committee. Many of these activities will interface with other departments and the Medical Staff. They are expected to do the following:

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

Employees

A. The role of the individual employee is critical to the success of a performance improvement

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

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

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

D. Employees are expected to do the following:

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

PERFORMANCE IMPROVEMENT STRUCTURE

Medical Staff Quality Assessment Committee

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

The Medical Staff Quality Assessment Committee:

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

B. Regularly reviews progress to the aforementioned plans;

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

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

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

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

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

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

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

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

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

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

Performance Improvement Committee (PIC)

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

B. The Performance Improvement Committee will:

    1. Oversee the Performance Improvement activities including data collection, data analysis, improvement, and communication to stakeholders;
    2. Set performance improvement priorities that focus on high-risk, high volume, or problem prone areas;
    3. Guide the department to and/or provide the resources to achieve improvement;
    4. Reviews requests for chartered Performance Improvement Teams. Requests for teams may come from committees, department or individual employees. Not all

performance improvement efforts require a chartered team;

5. Report the committee's activities quarterly to the Medical Staff Quality Committee.

SCIENTIFIC METHOD FOR IMPROVEMENT ACTIVITIES

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

Performance Improvement Teams

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

B. Performance Improvement Teams will:

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

PERFORMANCE IMPROVEMENT EDUCATION

A. Training and education are essential to promote a culture of quality within the Tahoe Forest Health System. All employees and Medical Staff receive education about performance improvement upon initial orientation. Employees and Medical Staff receive additional training on various topics related to performance improvement.

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

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

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

PERFORMANCE IMPROVEMENT PRIORITIES

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

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

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

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

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

DESIGNING NEW AND MODIFIED PROCESSES/FUNCTIONS/ SERVICES

A. Tahoe Forest Health System designs and modifies processes, functions, and services with quality in mind. When designing or modifying a new process the following steps are taken:

    1. Key individuals, who will own the process when it is completed, are assigned to a team led by the responsible individual.
    2. An external consultant is utilized to provide technical support, when needed.

3. The design team develops or modifies the process utilizing information from the following concepts:
    a. It is consistent with our mission, vision, values, and strategic priorities and meets the needs of individual served, staff and others
    b. It is clinically sound and current
    c. Current knowledge when available and relevant, i.e., practice guidelines, successful practices, information from relevant literature and clinical standards
    d. It is consistent with sound business practices
    e. It incorporates available information and/or literature from within the organization and from other organizations about potential risks to patients, including the occurrence of sentinel/near-miss events, in order to minimize risks to patients affected by the new or redesigned process, function, or service
    f. Conducts an analysis, and/or pilot testing, to determine whether the proposed design/redesign is an improvement and implements performance improvement activities, based on this pilot
    g. Incorporates the results of:
        i. performance improvement activities
        ii. consideration of staffing effectiveness
        iii. consideration of patient safety issues
        iv. consideration of patient flow issues
4. Performance expectations are established, measured, and monitored. These measures may be developed internally or may be selected from an external system or source. The measures are selected utilizing the following criteria:
    a. identify the events it is intended to identify
    b. a documented numerator and denominator or description of the population to which it is applicable
    c. defined data elements and allowable values
    d. detect changes in performance over time
    e. allow for comparison over time within the organization and between other entities
    f. data to be collected is available
    g. results can be reported in a way that is useful to the organization and other interested stakeholders

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

PROACTIVE RISK ASSESSMENTS

A. Risk assessments are conducted to pro-actively evaluate the impact of buildings, grounds, equipment, occupants, and internal physical systems on patient and public safety. This includes, but is not limited to, the following:

1. A Failure Mode and Effect Analysis (FMEA) will be completed based on the organization's assessment and current trends in the health care industry, and as approved by PIC or the MS QAC.
2. The Medical Staff Quality Committee, and other leadership committees, will recommend the processes chosen for proactive risk assessments based on literature, errors and near miss events, sentinel event alerts, and the CAH National Patient Safety Goals (NPSGs).
    a. The process is assessed to identify steps that may cause undesirable variations, or “failure modes”.
    b. For each identified failure mode, the possible effects, including the seriousness of the effects on the patient are identified and the potential breakdowns for failures will be prioritized.
    c. Potential risk points in the process will be closely analyzed, including decision points and patient’s moving from one level of care to another through the continuum of care.
    d. For the effects on the patient that are determined to be “critical”, an event analysis/root cause analysis is conducted to determine why the effect may occur.
    e. The process will then be redesigned to reduce the risk of these failure modes occurring or to protect the patient from the effects of the failure modes.
    f. The redesigned process will be tested and then implemented. Performance measurements will be developed to measure the effectiveness of the new process.
    g. Strategies for maintaining the effectiveness of the redesigned process over time will be implemented.
3. Ongoing hazard surveillance rounds, including Environment of Care Rounds, and departmental safety hazard inspections, are conducted to identify any trends and to provide a comprehensive ongoing surveillance program.
4. The Environment of Care Safety Officer and EOC/Safety Committee review trends and incidents related to the Safety Management Plans. The EOC Safety Committee provides guidance to all departments regarding safety issues.
5. The Infection Preventionist, and Environment of Care Safety Officer, or designee, complete a written infection control and pre-construction risk assessment for interim life safety for new construction or renovation projects.

DATA COLLECTION

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

1. Medication therapy
2. Adverse event reports
3. National patient safety goals
4. Infection control surveillance and reporting
5. Surgical/invasive and manipulative procedures
6. Blood product usage, including transfusions and transfusion reactions
7. Data management
8. Discharge planning
9. Utilization management
10. Complaints and grievances
11. Restraints/seclusion use
12. Mortality review
13. Medical errors including medication, surgical, and diagnostic errors; equipment failures, infections, blood transfusion related injuries, and deaths due to seclusion or restraints
14. Needs, expectations, and satisfaction of individuals and organizations served, including:
    a. Their specific needs and expectations
    b. Their perceptions of how well the organization meets these needs and expectations
    c. How the organization can improve patient safety
    d. The effectiveness of pain management
15. Resuscitation and critical incident debriefings
16. Unplanned patient transfers/admissions
17. Medical record reviews
18. Performance measures from acceptable data bases/comparative reports, i.e., RL Datix Event Reporting, QCentrix, NDNQI, HCAHPS, Care Compare, QualityNet, HSAG HIIN, MBQIP, HCAI, and Press Ganey, etc.
19. Summaries of performance improvement actions and actions to reduce risks to patients

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

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

AGGREGATION AND ANALYSIS OF DATA

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

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

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

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

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

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

REPORTING

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

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

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

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

E. Tahoe Forest Health System also recognizes the importance of collaborating with state agencies to improve patient outcomes and reduce risks to patients by participating in quality

reporting initiatives (See Attachment E for External Reporting listing).

CONFIDENTIALITY AND CONFLICT OF INTEREST

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

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

ANNUAL ASSESSMENT

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

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

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

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

PLAN APPROVAL

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

Related Policies/Forms:

Available CAH Services, TFH & IVCH, AGOV-06

Medication Error Reduction Plan, APH-34

Medication Error Reporting, APH-24

Infection Control Plan, AIPC-64

Environment of Care Management Program, AEOC-908

Utilization Review Plan (UR), DCM-1701

Risk Management and Patient Safety Plan, AQPI-02

Emergency Operations Plan (Comprehensive), AEOC-17

Discharge Planning, ANS-238

Employee Health Plan, DEH-39

Quality Assurance and Performance Improvement Program, DHH-1802

Quality Assurance and Performance Improvement Program, DHOS-1801

References:

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

Attachments

A. Quality Initiatives 2025.docx

B. QA PI Reporting Matrix 2025.xlsx

C. QI Indicator Definitions 2025.docx

D. External Reporting 2025.docx

E. Quality Reporting Programs 2025.xlsx

Approval Signatures

Step Description	Approver	Date

2024 Critical Access Hospital

National Patient Safety Goals*

Updated for Tahoe Forest Hospital District CY 2024

National Patient Safety Goals	*Summary of Activities Calendar Year 2024*

Improve the accuracy of patient identification
• Use at least two patient identifiers when providing care, treatment, and services.
• Use at least two identifiers when administering medications, blood, or blood components; when collecting blood samples and other specimens for clinical testing; and when providing treatments or procedures
• Patient's room number or physical location is not used as an identifier
• Label containers used for blood and other specimens in the presence of the patient
• Use distinct methods of identification for newborn patients
	• Safety First on two patient identifiers every time.
	• Safety First, and re-education on proper specimen labeling.
	• Customization/standardization to provider documentation for notes to pull in adequate patient information.
	• Reinforcement/education on OR specimen collection policy and procedure and checklist created.
	• Patient Registration project to improve quality and accuracy of patient information being entered into the chart during registration process, including promoting use of interpreter services.
	• RMT subgroup collaborating on standard work for labeling specimens.
	• ED to ASD handoff checklists created for patients going to OR from ED.
	• Policies:
	  ○ Floor collected Specimen, ANS-43
	  ○ Specimen Collection and Handling, DOR-2015
	  ○ Patient Identification and Specimen Labeling, PHL-S0030
	  ○ Patient Identification and Arm Banding, AGOV-1801
	  ○ Neonate – Patient Admission Care and Discharge of, DWFC-1449
	  ○ Postpartum – Patient Care and Discharge of, DWFC-1466

Improve the effectiveness of communication among caregivers • Report critical results of tests and diagnostic procedures on a timely basis • Develop and implement written procedures for managing the critical results of tests and diagnostic procedures • Evaluate the timeliness of reporting the critical results of tests and diagnostic procedures	• Emergency Departments in Truckee and Incline Village collaborating with Beta Zero Harm Collaborative on improved handoff communication; including standard work and handoff tools. • Improved communication process for labs resulted after patient discharged from Emergency Departments • All clinical staff attend 3.5 hours of Clinical Orientation on hire. Training includes: clinical resources**, SBAR/CUS and chain of command**, ancillary departments, infection

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** National Patient Safety Goals® Effective January 2024 for the Critical Access Hospital Program*
Last updated by A. Davis, December 2024

	prevention, medical codes and code response, safe patient handling, O2 safety, MRI safety and other topics.
	• SBAR, CUS & handoff policies in place. Ongoing education of these principals in weekly huddles, Pacesetter, Medical Staff meetings, clinical orientation, unit skills days and mock codes.
	• DI/Lab performs monthly quality checks with follow up for non-compliance.
	• Continued efforts to improve and standardize handoff; including promoting bedside shift report, provider-MA use of SBAR in clinics, improved handoff between ED and OR.
	• Policies:
	  ○ Critical Value Reporting, ALB-S1700
	  ○ Critical Results Reporting Radiology, DXR-66

Improve the safety of using medications • Before a procedure, label medicines that are not labeled. For example, medicines in syringes, cups and basins. Do this in the area where medicines and supplies are set up. • Take extra care with patients who take medicines to thin their blood. • Record and pass along correct information about a patient's medicines. Find out what medicines the patient is taking. Compare those medicines to new medicines given to the patient. Give the patient written information about the medicines they need to take. Tell the patient it is important to bring their up-to-date list of medicines every time they visit a doctor.	• Smartpumps – EMR integration went live in March 2024. Integrating pumps and EMR improves efficiency and safety. Now data and reports are available from smartpump and pharmacy software to analyze how nursing is using pumps and drug library. • Pump Integration committee established (pharmacy, nursing leaders, Patient Safety, anesthesia, frontline nurses). • Biweekly medication event reviews with pharmacy, quality, and nursing leadership. • Shared case study and lessons learned after medication administration error. Action plan included introducing insulin pens to formulary to increase patient safety. • Monitoring bar code scanning rates and processes by caregivers to identify areas for improvement. • Continue to maintain and improve our current CPOE system, as evidence-based recommendations evolve, or in response to event reports. • Medication Reconciliation Process Improvement team continues to work

	diligently to improve the efficiency and accuracy. IVCH RNs doing daily audits to ensure correct pharmacy is entered into Epic so prescriptions go to correct location; also do follow up phone calls to make sure patient obtained correct medications and answer questions. • Quarterly Med Safety & P&T Committee, which oversees MERP • Director of Pharmacy (DoP) attends all Medical Staff Meetings and daily Admin Huddle • DoP is the antimicrobial stewardship leader and reports through P & T committee • DoP is member of Inpatient Glycemic Management • DoP is member of order set team • VTE order set • Staff VTE education & monitoring • Daily EMR surveillance and reporting on compliance of VTE prophylaxis in the safety rounds. • VTE order set • Pharmacy monitoring protocols for dosing anticoagulants. • Pre-Admit RNs are changing the way they communicate and document PTA med rec so that their pre-procedure medication patient instructions are clearly visible to providers and to ensure Anesthesia can see how the patient takes medications in contrast to how it is prescribed • Policies: o Medication Administration, APH-23 o Reconciliation of Medications, APH-31 o Label Medications and Solutions on the Sterile Field, DOR-2205 o Anticoagulation Protocol, APH-1401 o Outpatient RN Anticoagulation Protocol, APH-1701
Reduce patient harm associated with clinical alarm systems • Leaders establish alarm system safety as a critical access hospital priority	• Training and education related to alarms and monitoring provided as new equipment is introduced in health system. • Policies:

• Make improvements to ensure that alarms on medical equipment are heard and responded to on time	○ Audibility of Clinical Monitoring, ANS-7
Reduce the risk of health care-associated infections • Use the hand cleaning guidelines from the Centers for Disease Control and Prevention or the World Health Organization • Set goals for improving hand cleaning	• Policy, staff education, and audit in place for influenza prevention. Approved & reported to IC Committee. • Continued work by Infection Preventionist on hospital-wide flu vaccination program and monitoring. • Flu vaccines mandatory for employees. • Policy, staff education, and unit-based hand hygiene compliance observation and self-reporting in place. Approved & reported to IPC Committee. • COVID mitigation plan revised as needed. • Real time concurrent sepsis and pain assessment reviews/audits and reminders for compliance sent to staff. • DI auditing sterile technique compliance for all PICC lines placed. • Using CLIP for all central line insertions. • Chlorhexidine Gluconate (CHG) bathing of ICU patients, and patients with devices, (e.g. central lines, indwelling catheters) or on contact precautions. • Central line competency and return-demonstration for all new hire RNs. • Sepsis initiatives ongoing including case reviews and September Sepsis Awareness month. • All clinical staff attend 3.5 hours of Clinical Orientation on hire. Training includes: clinical resources, SBAR/CUS and chain of command, ancillary departments, infection prevention, medical codes and code response, safe patient handling, O2 safety, MRI safety and other topics. • CHG bathing policy and nursing staff provided ongoing education. • Decolonization practices: CHG bathing, oral and nasal decolonization. • Policy, staff education, and audit in place. Approved & reported to IPC Committee &

	NHSN. • EMR surveillance and monthly post discharge surveillance reports to surgeons to identify SSIs. • SSI track & trend report reviewed with Medical Staff and areas for improvement discussed. • Surgery and Orthopedics departments participated in AHRQ MRSA CUSP for total joint surgeries. As part of AHRQ MRSA prevention program, universal decolonization for surgical patients: CHG showers/wipes, povidone iodine nasal decolonization, oral decolonization. • As part of AHRQ MRSA prevention program, Standardize and monitor MRSA screen testing on planned inpatient admissions on total joint arthroplasty patients. • Obstetrics department participated in CMQCC maternal sepsis initiative. • Surveillance on MDROs – electronic and by walking around to ensure transmission-based precautions are followed for applicable patients, hand hygiene is performed, and PPE is selected and used appropriately; NHSN reporting of Healthcare Associated conditions. • Foley justification addressed at daily interdisciplinary huddles. • Foley Policy, education, order set & audit in place. • Policies: ○ Hand Hygiene and Glove Use, AIPC-46 ○ Chlorhexidine (CHG) Bathing, AIPC-2003 ○ Ultrasound Transducers/Probes Cleaning and Disinfection, AIPC-2301 ○ Central Line Insertion Practices (CLIP), AIPC-11 ○ Infection Prevention and Control Plan, AIPC-64
The critical access hospital identifies safety risks inherent in its patient population • Reduce the risk for suicide	• Zero Suicide Initiative Leadership meets monthly and promotes education, awareness, and policy and practice guideline improvement through data analytics,

	consistent feedback and collaboration with community partners throughout the year. • Member of peer support trained as a Group Crisis Interventionist • Member of peer support trained as Mental Health First Aid Instructor to provide in-house education and expand mental health first aid instruction opportunities inside the organization. • Anchor Box program rolled out in various locations in the district. • Peer Support team grew to over 40 members in 2024. • Policies: ○ Management and Screening of Mental Health Patients at Risk for Suicide/Self-Harm/Harm to Others, AGOV-2101

Improve health care equity
• Improving health care equity is a quality and patient safety priority. For example, health care disparities in the patient population are identified and a written plan describes ways to improve health care equity
	• Community Health Advocates supporting patients with complex medical and health-related social needs by providing culturally appropriate education and support to improve patient comprehension and health outcomes.
	• $30,000 grant received from Martis Camp went towards the treatment of perinatal and anxiety disorder. The money is allocated to assist any patient with a financial need to receive necessary care without concern for cost.
	• Patient Registration project to improve quality and accuracy of patient information being entered into the chart during registration process, including promoting use of interpreter services.
	• "Everyone" education via Safety First about language line and interpreter services available at TFHD.
	• Policies:
	  ○ Standards of Professional Performance, ANS-109
	  ○ Interpreter and Translator Services, DPTREG-2001

Prevent mistakes in surgery	• Continued focus on proper informed consent processes in procedural areas.

• Make sure that the correct surgery is done on the correct patient and at the correct place on the patient's body.
• Mark the correct place on the patient's body where the surgery is to be done.
• Pause before the surgery to make sure that a mistake is not being made
	• Ongoing review of Consent processes and ensuring best practices are followed; altering forms and process as needed to keep up with best practice recommendations.
	• Timeout policy and checklist available with ongoing staff education, and auditing of practice.
	• Policies:
	  ○ "Time-Out" for Invasive Procedures, DED-36
	  ○ Time Out for Surgical and Invasive Procedures, DOR-2209
	  ○ Time-Out for Procedures Done Outside the OR, ANS-114
	  ○ RT – Patient, Procedure, Site, Side Verification, DCC-119

CMS Framework for Health Equity 2022–2032

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CMS Office of Minority Health Director's Foreword

"As the nation's largest health insurer, the Centers for Medicare & Medicaid Services has a critical role to play in driving the next decade of health equity for people who are underserved. Our unwavering commitment to advancing health equity will help foster a health care system that benefits all for generations to come."

Dr. Martin Mendoza, Director, CMS Office of Minority Health,
Chief Health Equity Officer, CMS

The *CMS Framework for Health Equity* provides a strong foundation for our work as a leader and trusted partner dedicated to advancing health equity, expanding coverage, and improving health outcomes. This includes strengthening our infrastructure for assessment, creating synergies across the health care system to drive structural change, and identifying and working together to eliminate barriers to CMS-supported benefits, services, and coverage for individuals and communities who are underserved or disadvantaged and those who support them.

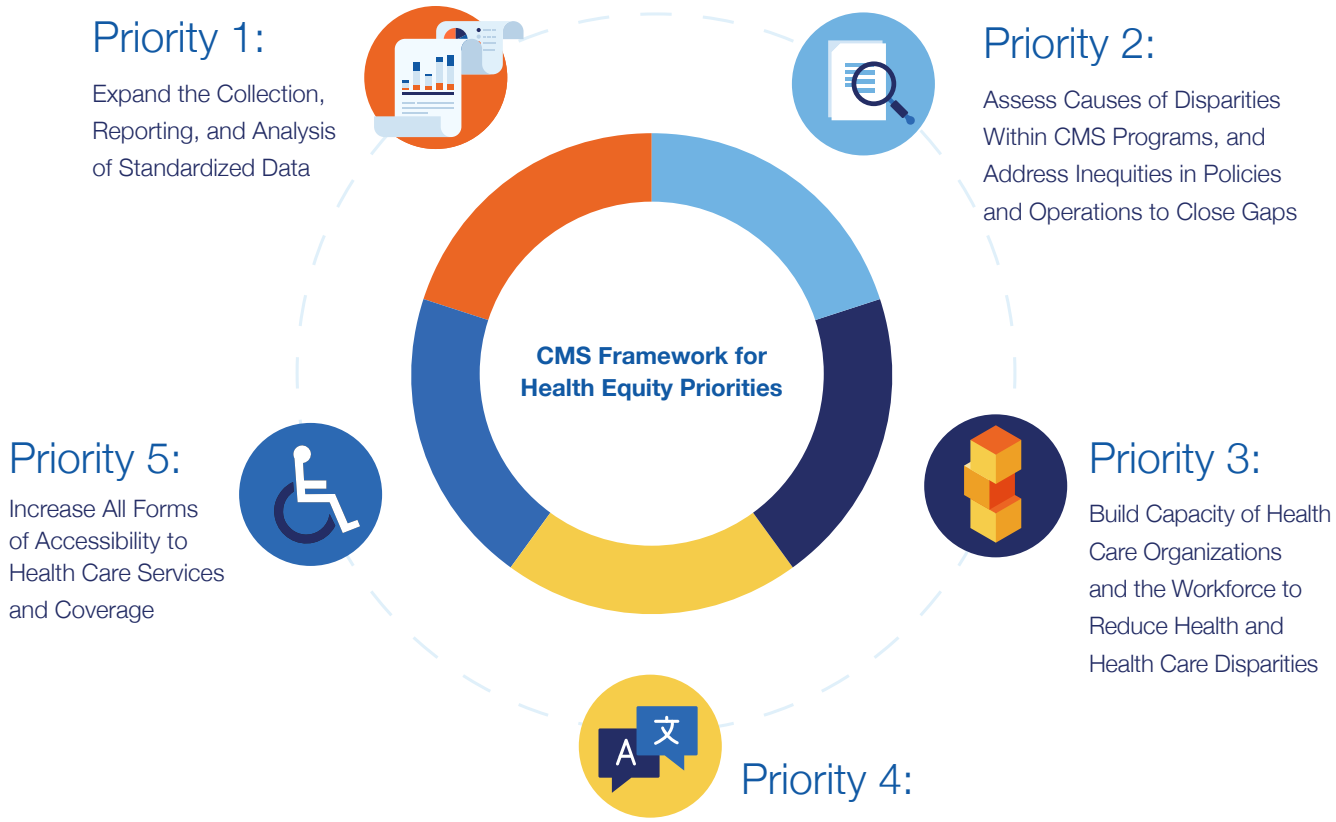
Across our Centers and Offices, we are committing to taking an integrated, action-oriented approach to advance health equity among members of communities, providers, plans, and other organizations serving such communities, who are underserved or disadvantaged.

We strive to identify and remedy systemic barriers to equity so that every one of the people we serve has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes.

This Framework challenges us to incorporate health equity and efforts to address health disparities as a foundational element across all our work, in every program, across every community. We are designing, implementing, and operationalizing policies and programs that support health for all the people served by our programs, eliminating avoidable differences in health outcomes experienced by people who are disadvantaged or underserved, and providing the care and support that our enrollees need to thrive.

Executive Summary

CMS is the largest provider of health insurance in the United States, responsible for ensuring that more than 170 million individuals supported by CMS programs (i.e., Medicare, Medicaid, Children's Health Insurance Program (CHIP), and the Health Insurance Marketplaces) are able to get the care and health coverage they need and deserve.[1] Consistent with the Department of Health and Human Services' Healthy People 2030 Framework,[2] CMS recognizes that addressing health and health care disparities and achieving health equity should underpin efforts to focus attention and drive action on our nation's top health priorities. CMS defines health equity as the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes.[3]



The *CMS Framework for Health Equity* is consistent with the Healthy People 2000 Framework which first incorporated health equity as a guiding objective as well as other efforts undertaken across HHS to address health equity and disparities reduction as a critical aspect of health and health care. The Framework is also consistent with the bold goals CMS Centers and Offices have articulated in our program areas, including Medicaid and CHIP and the CMS Innovation Center.[4, 5] This Framework reinforces the concept that in order to attain the highest level of health for all people, we must give our focused and ongoing attention to address avoidable inequalities and eliminate health and health care disparities.[6]

Consistent with Executive Order 13985 on Advancing Racial Equity and Support for Underserved Communities Through the Federal Government, the term "underserved communities" refers to populations sharing a particular characteristic, including geographic communities that have been systematically denied a full opportunity to participate in aspects of economic, social, and civic life, as exemplified in the definition of "equity."[7] This includes members of racial and ethnic communities, people with disabilities, members of the lesbian, gay, bisexual, transgender, and queer (LGBTQ+) community, individuals with limited English proficiency, members of rural communities*, and persons otherwise adversely affected by persistent poverty or inequality.[8, 9]

This plan focuses on people who experience, or serve those who experience, disproportionately high burdens of disease, worse quality of care and outcomes, and barriers to accessing care. The *CMS Framework for Health Equity* was developed with particular attention to disparities in chronic and infectious diseases such as diabetes, chronic kidney disease, cancer, dementia, cardiovascular disease, maternal and infant health, behavioral health, as well as HIV/AIDS, and COVID-19, which disproportionately impact members of underserved communities due to prevalence, complexity, and social risk factors.[10, 11, 12, 13, 14, 15, 16] This plan also considers the impacts natural disasters (e.g., earthquakes, fires, viral outbreaks) and manmade disasters (e.g., oil spills, lead poisoning, climate change) have on specific communities — both during an event and in response and recovery — as health and social risk factors may work together to cause or worsen existing health and health care disparities.[17, 18, 19, 20, 21]

This *CMS Framework for Health Equity* updates the previous Medicare-focused *CMS Equity Plan for Improving Quality in Medicare* [22] with an enhanced and more comprehensive 10-year approach to further embed health equity across all CMS programs including Medicare, Medicaid, CHIP, and the Health Insurance Marketplaces.

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* In referencing members of rural communities, we are inclusive of individuals in frontier areas, tribal lands, and those residing in the U.S. territories.

The updated *CMS Framework for Health Equity* also brings focus to CMS's work supporting health care organizations, health care professionals and partners — providers, health plans, federal, state, and local partners, tribal nations, individuals and families, quality improvement partners, researchers, policymakers, and other stakeholders — in activities to achieve health equity. The initial *CMS Equity Plan for Improving Quality in Medicare* identified high-impact priorities based on stakeholder engagement, a review of the evidence base, and discussions across HHS, CMS, and among federal partners. This enhanced and expanded *CMS Framework for Health Equity* refines CMS's health equity priorities and broadens our focus beyond Medicare. It is informed by the seven interim years of stakeholder input, evidence review, and knowledge and understanding gained through the Agency's work. The five priorities of this new, enhanced, and comprehensive *CMS Framework for Health Equity* are described in detail throughout this plan. These priorities encompass both system and community-level approaches to achieve equity across CMS programs. Each of the priorities are complementary, and their integrated adoption and implementation is central to the elimination of barriers to health equity for all Americans.

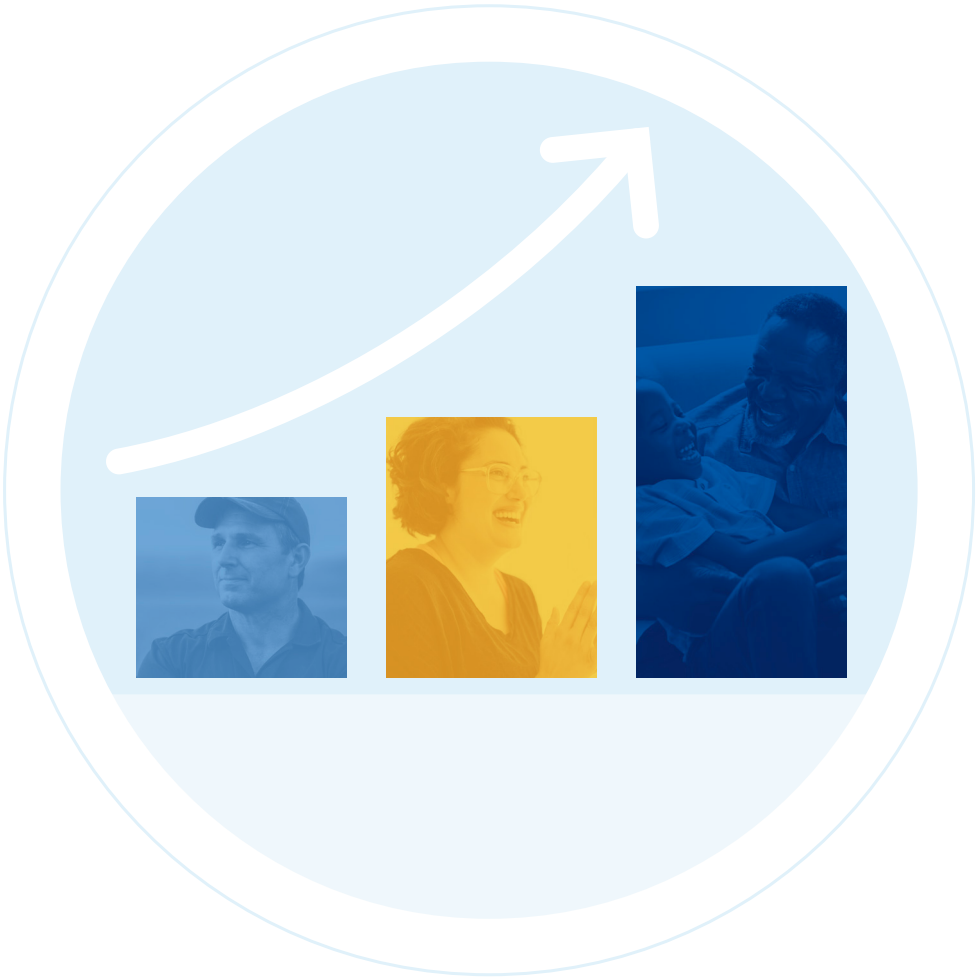
This plan aligns with the federal government's goal in advancing equity, which is to provide everyone with the opportunity to reach their full potential.[23] Consistent with this aim, the *CMS Framework for Health Equity* supports CMS's ability to assess whether, and to what extent, its programs and policies perpetuate or exacerbate systemic barriers to opportunities and benefits for the communities referenced above. This includes understanding and addressing the ways in which Medicare, Medicaid, CHIP, and the Health Insurance Marketplaces (Marketplaces) meet the needs of those we serve, particularly underserved communities and individuals.

CMS will identify, establish, and monitor progress of our efforts across the Agency. We will draw on CMS data and other available sources to monitor and assess whether disparities in health and health care quality, access, and outcomes are improving across CMS programs and among the individuals we serve. Our progress in advancing health equity will reflect our commitment to continuous quality improvement for all individuals, and we will incorporate ongoing input from those that participate in CMS programs — our communities, providers, plans, and other partners — to help us innovate and improve over time. True success will be realized only when all those served by CMS have achieved their highest level of health and well-being, and that we have eliminated disparities in health care quality and access. While this vision may not be fully attainable in the ten-year horizon of this plan, we will report on our progress and continuously identify opportunities to improve.

Aligning with CMS and HHS

The United States has made progress towards improving health care quality, but well-documented disparities persist for members of racial and ethnic communities, people with disabilities, members of the LGBTQ+ community, individuals with limited English proficiency, members of rural communities, and persons otherwise adversely affected by persistent poverty or inequality.[24, 25, 26, 27] CMS promotes health equity by using policy levers and program authorities and engaging health care stakeholders across settings and communities. We consistently identify and disseminate new and promising practices and embed health equity into CMS programs to better meet the needs of all communities — particularly underserved communities. In addition, we facilitate knowledge sharing and collaboration among stakeholders and engage with new audiences to expand and extend efforts to achieve equity. In particular, CMS leverages existing and new quality improvement initiatives to support and amplify best practices that are proven to address social risk factors and unmet social needs and reduce disparities.

The *CMS Framework for Health Equity* is structured to align with HHS initiatives that seek to achieve health equity and reduce disparities among minority and underserved populations. This includes the Healthy People 2030 Framework,[28] which establishes the foundational principle that "achieving health and well-being requires eliminating health disparities, achieving health equity, and attaining health literacy."[29] This also includes but is not limited to Department-wide strategies and approaches to embedding health equity across our program — for example, the HHS Rural Action Plan,[30] the HHS Maternal Health Action Plan,[31] the HHS National Standards for Culturally and Linguistically Appropriate Standards (CLAS) in Health and Health Care,[32] the HHS National Quality Strategy,[33] and the IHS Strategic Plan which ensures that across HHS we are providing federal health services to American Indian and Alaska Native people.[34] Healthy People 2030 also outlines a Social Determinants of Health (SDOH) Framework[35] with five domains including economic stability, education access and quality, health care access and quality, neighborhood and built environment, and social and community context. Healthy People 2030 and related work across HHS underscores that social risk factors and unmet social needs contribute to wide health and health care disparities and inequities. Stakeholders across the health care spectrum have a role to play in addressing social determinants of health.[36]



Of primary and critical importance, the *CMS Framework for Health Equity* aligns across CMS initiatives and other existing strategy documents such as the Administrator's Strategic Vision for CMS,[37] the CMS Rural Health Strategy,[38] the CMS Quality Strategy,[39] the CMS Innovation Center's Strategy Refresh,[40] and CMS's Strategic Vision for Medicare and CHIP.[41] These strategies focus on eliminating disparities as a cross-cutting criteria to be applied throughout the Agency's work. The *CMS Framework for Health Equity* also aligns with other Agency-wide efforts, particularly strengthening infrastructure and data systems, empowering individuals, families, and caregivers as partners in their health care, and addressing the need for measures for population-based payment through alternative payment models. Work across these areas supports the Agency in monitoring trends in quality of care and health outcomes, learning directly from the communities and families CMS serves, and incorporating population health improvement activities into measurement and payment. All of these activities are essential to achieving health equity across care settings and health conditions.

Priorities for the 2022–2032 *CMS Framework for Health Equity*

The next section of the *CMS Framework for Health Equity* outlines five priorities that inform CMS's efforts for the next ten years and how the Agency may operationalize each priority to achieve health equity and eliminate disparities. Each priority area reflects a key area in which CMS stakeholders from communities that are underserved and disadvantaged express that CMS action is needed and critical to advancing health equity. Together, the five priorities provide an integrated approach to build health equity into existing and new efforts by CMS and our stakeholders.

Priority 1: Expand the Collection, Reporting, and Analysis of Standardized Data

CMS strives to improve our collection and use of comprehensive, interoperable, standardized individual-level demographic and SDOH data, including race, ethnicity, language, gender identity, sex, sexual orientation, disability status, and SDOH. By increasing our understanding of the needs of those we serve, including social risk factors and changes in communities' needs over time, CMS can leverage quality improvement and other tools to ensure all individuals have access to equitable care and coverage.

Priority 2: Assess Causes of Disparities Within CMS Programs, and Address Inequities in Policies and Operations to Close Gaps

CMS is committed to move beyond observation and into action, assessing our programs and policies for unintended consequences and making concrete, actionable decisions about our policies, investments, and resource allocations. Our goals are to explicitly measure the impact of our policies on health equity, to develop sustainable solutions that close gaps in health and health care access, quality, and outcomes, and to invest in solutions that address health disparities.

Priority 3: Build Capacity of Health Care Organizations and the Workforce to Reduce Health and Health Care Disparities

CMS has a commitment to support health care providers, plans, and other organizations who ensure individuals and families receive the highest quality care and services. Health care professionals, particularly those serving minority and underserved communities, have a direct link to individuals and families and can address disparities at the point of care. CMS policy, program, and resource allocation decisions must build capacity among providers, plans, and other organizations to enable stakeholders to meet the needs of the communities they serve.

Priority 4: Advance Language Access, Health Literacy, and the Provision of Culturally Tailored Services

CMS must ensure that all individuals we serve, including members of communities that are underserved, can equitably access all CMS benefits, services and other supports, and coverage. Language access, health literacy, and the provision of culturally tailored services play a critical role in health care quality, patient safety and experience, and can impact health outcomes. CMS has opportunities across our operations, direct communication and outreach to enrollees and consumers, and guidance to plans, providers, and other partners to improve health care quality, patient safety, and the experience individuals have within the health care system.

Priority 5: Increase All Forms of Accessibility to Health Care Services and Coverage

CMS has a responsibility to ensure that individuals and families can access health care services when and where they need them, in a way that is responsive to their needs and preferences. CMS must seek direct feedback from individuals with disabilities, including physical, sensory and communication, intellectual disabilities, and other forms of disability, to understand their experiences navigating CMS-supported benefits, services, and coverage and tailor our programs and policies to ensure equitable access and quality.

Priority 1: Expand the Collection, Reporting, and Analysis of Standardized Data

A growing body of literature suggests that increasing the collection of standardized demographic and language data across health care systems is an important first step towards improving population health.[42, 43, 44, 45] In addition, certain settings — including Post-Acute Care and Home and Community Based Services — offer unique opportunities to connect individuals with social services while receiving health care services and as they transition across care settings. Data on social risk factors, experience of care, and comprehensive patient demographic data, including race, ethnicity, language, gender identity, sex, sexual orientation, and disability status is a valuable tool for quality improvement. This data collection should be voluntary for individuals to ensure individuals are protected, and existing data should be leveraged to ensure alignment across HHS and other federal agencies. Increasing available standardized data across settings and programs enables CMS and our stakeholders to address changes in populations over time and leverage information to connect individuals to appropriate and needed social services and supports. This also includes understanding and standardizing data collection across other federal agencies serving underserved communities, including tribal communities, rural communities, and programs with benefits that address individuals' social risk factors and unmet social needs.

Health outcomes and experience of care are driven by the conditions in the environment, or SDOH, where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.[46] For example, individuals with unmet social needs including inadequate access to food or stable housing are at greater risk of developing chronic conditions and experience more difficulty managing those conditions.[47] Communities experiencing persistent poverty or inequality tend to disproportionately experience unmet social needs. Communities may experience structural barriers which can create disparities including exposure to toxins and environmental hazards, limited choice and access to health care services, and can lead to widespread viral transmission across communities — creating sickness and diminishing opportunities to seek appropriate care.[48, 49] Further, because of social risk factors or underlying health risks, some communities may also experience disproportionate impacts of natural and manmade disasters and require unique or tailored emergency response services or treatment.[50, 51] Healthy People 2030 groups SDOH into five domains, including economic stability, educational access and quality, health care access and quality, neighborhood and built environment, and social and community context. SDOH data can include information on health literacy, transportation, social isolation, housing insecurity, food insecurity, geography, and more.[52]

For Example: In the FY2020 Prospective Payment System Rules for Post-Acute Care Settings Including Skilled Nursing Facilities,[53] Inpatient Rehabilitation Facilities,[54] Home Health Agencies,[55] and Long-Term Care Hospitals,[56] CMS added seven Standardized Patient Assessment Data Elements (SPADEs) to the patient assessment tools related to demographic and SDOH data. Patient assessments now collect race, ethnicity, preferred language, need for interpreter, health literacy, transportation and social isolation for the first time, giving CMS and our stakeholders the ability to tailor programs and policies in post-acute care settings based on needs and disparities.

Developments in health information technology have significantly improved the ability to measure disparities at the provider level.[57] The need for complete and accurate demographic and SDOH data is promoted widely within the provider community and encouraged by federal programs and policies. In addition, individuals' use of technology can help CMS leverage patient self-reported data obtained through technology among certain underserved communities. For example, about 8 in 10 White, Black, and Hispanic adults own a smartphone; about a quarter of Black and Hispanic adults primarily access the internet using mobile devices, meaning they may lack traditional broadband internet and use smartphones to access information online.[58] However, underserved communities have higher rates of cut off or suspended smartphone service.[59] If individuals have a smartphone and are able to reliably use the device to access the internet, this technology can help CMS harness data directly from individuals we serve to augment provider data collection. However, CMS must be mindful of the disparities in access to technology among underserved or disadvantaged communities, including rural areas and Indian reservations lacking broadband access, and ensure that provider and patient self-reported data collection is standardized and accessible across settings, regions, and communities such that no individual the Agency serves is excluded.

Demographic, SDOH, and social risk factor information can help drive quality improvement and dramatically improve CMS's ability to evaluate changes in the prevalence of SDOH and social risk factors, and their influence on health outcomes. To ensure individual choice and privacy, this data collection should be voluntary. However, CMS may use information it is able to collect and leverage from other sources to support health care organizations in building strategic relationships with other local community partners to better understand and meet patients' unmet social needs. Better quality, linked data can also enhance emergency and disaster readiness, response, and recovery as federal agencies seek to target resources and tailor policies. For these reasons, data standardization, interoperability, and accessibility of one's own clinical information are critical to improving health outcomes.

CMS's collaboration with the HHS Office of the National Coordinator for Health Information Technology (ONC) and others to advance interoperability and bring administrative and clinical data together is important not just to identify patients with social risk factors, but also to make sure individuals in underserved communities and their providers have access, as appropriate, to the information they need for decision-making. Examples of initiatives under which HHS and CMS are working in partnership include, but are not limited to: the 2011 HHS Data Standards,[60] United States Core Data for Interoperability (USCDI) standards,[61] HHS Disparities Action Plan,[62] HHS Office of the Assistant Secretary for Planning and Evaluation (ASPE) Social Risk and Medicare's Value Based Purchasing Programs Report to Congress,[63] CMS Accountable Health Communities Model,[64] data elements in CMS surveys and assessments including the SPADEs[65] collected across Post-Acute Care settings and Consumer Assessment of Healthcare Providers & Systems (CAHPS)[66] surveys collected across all health care settings, meaningful use incentives, and the ONC's interoperability initiatives addressing social determinants of health data elements.[67, 68, 69, 70]

CMS will continue to work within our Agency's statutory authorities to strengthen our collection of accurate and reliable data on social risk factors and SDOH across health care settings and systems and in doing so, will also seek to better understand and address the barriers to collecting and using this data. Across our Centers and Offices, CMS is committed to improving data collection and reporting. For example, the CMS Innovation Center will require all new model participants to collect and report demographic data of their enrollees and, as appropriate, data on social needs and SDOH. We are also mindful of the need to ensure privacy and safety of individuals' personal health information and protection from data breaches and discrimination, and data would be collected in a manner that complies with HIPAA and all other applicable laws.[71] In addition, Medicaid and CHIP are centrally focused on ensuring our data is accurate and that we can measure progress against a baseline with clear, consistent, and comparable stratification of critical quality and outcome metrics across the program. To advance these aims, CMS will work with states to improve measurement of health disparities across a core set of stratified metrics.[72]

Through collaboration with federal and external partners, we will work to advance our shared goal of standardized collection of these data elements. This collaborative effort supports the health care system in driving improvements where they can have the greatest impact on health equity and reducing disparities. Further, it underpins CMS's — and the federal government's — ability to have data-driven responses to public health emergencies, disasters, and public health threats, and ensure we are responsive and appropriate in meeting the needs of underserved communities in times of crisis.

Priority 2: Assess Causes of Disparities Within CMS Programs, and Address Inequities in Policies and Operations to Close Gaps

CMS programs support the health of millions of individuals. This makes the Agency a critical engine for opportunities to center health equity in the delivery of health care, rulemaking, and policy development, related to benefit and payment design, data collection, quality improvement, and research. Several CMS programs and initiatives, such as the Network of Quality Improvement and Innovation Contractors,[73] the Center for Medicaid & CHIP Services Quality Improvement Program,[74] the Quality Payment Program,[75] Health Insurance Marketplace Quality Initiatives,[76] and Center for Medicare & Medicaid Innovation[77] models and demonstrations, have stated

that health equity and disparity reduction are a focus area or guiding principle.[78, 79, 80, 81, 82] CMS is developing consistent ways to assess each program's impact on health equity and engineering tailored solutions across communities and settings of care. Many opportunities exist across Medicare, Medicaid, CHIP, and the Health Insurance Marketplaces to enhance our understanding of how these programs impact unique communities and to design and test solutions. CMS continues to seek ways to systematically evaluate and assess our programs, policies, and operations for health equity impacts and drivers of disparities and strengthen our approach to care delivery, measurement, and payment to advance health equity among those we serve.

For example, HHS ASPE's Reports to Congress as mandated by the IMPACT Act[83] assessed the extent to which Medicare's value-based purchasing programs can and should account for individuals' social risk factors. Informed by HHS ASPE's Report to Congress, CMS has several options to further evaluate the impact that social risk factors have on payment and value-based purchasing programs. Deepening our understanding of the relationship between social risk factors and payment can help us identify drivers of disparities across programs and policies, and facilitate CMS-driven equity solutions related to unmet social needs that directly impact populations to reduce these disparities. In addition, as CMS centers health equity in health and health care, we may consider exploring opportunities to collaborate with our network of partners to engineer or test more proactive approaches to reducing disparities.

For Example: The CMS Innovation Center is focused on understanding the current impacts of its models across all patients and identifying areas for reducing inequities at the population level. One such example is the Medicare Advantage Value Based Insurance Design (VBID)[84] Model's Health Equity Incubation Program.[85] This Incubation Program is geared to help Medicare Advantage plans identify disparities among their enrollees and utilize flexibilities available through the VBID Models to close gaps and advance health equity by targeting enrollees who are eligible for a certain low-income subsidy or have chronic conditions.

This could include leveraging demographic and SDOH data and parts of the health care delivery system to enhance the way services are delivered. For example, identifying individuals who could benefit from social supports or home and community-based services and bringing needed services to individuals could improve quality and access in underserved communities.

In addition to addressing aspects of payment and service delivery, CMS has monitoring and oversight responsibilities related to Conditions of Participation (CoPs) and Conditions for Coverage (CfCs)[86] that health care organizations must meet in order to participate in our programs. These standards are the foundation for improving quality and protecting the health and safety of individuals receiving services from a health care organization. Reviewing these standards and considering ways to strengthen health care organizations to advance equity as they provide care is a critical policy lever. This helps CMS identify and eliminate potential barriers that underserved communities and individuals may face to enrollment in, and access to, CMS benefits and services. Further, CMS plays a pivotal role in ensuring health care professionals and health insurance issuers who receive funding through any CMS programs uphold civil rights laws and protections which prohibit discrimination based on race, color, national origin, sex, age, or disability. CMS has a responsibility to monitor and oversee health care organizations' adherence to these laws. CMS also has a responsibility to embed equity solutions and policies that safeguard these rights for all those we serve, particularly members of underserved or disadvantaged communities.

Finally, and of critical importance, CMS has a responsibility to increase access to health care coverage for underserved populations. Expanding and strengthening health care coverage, through Medicaid, CHIP, Medicare, and Health Insurance Marketplaces, have been some of CMS's most significant actions to improve health equity over the past decade. Within Medicaid and the Health Insurance Marketplaces in particular, coverage expansions and premium assistance have helped millions of individuals in underserved areas access covered health care services, many for the first time.[87, 88] However, disparities in coverage persist among members of racial and ethnic communities and others affected by systemic inequalities.[89, 90] Individuals, families, and caregivers in communities that are underserved or disadvantaged are more likely to experience gaps in coverage and underinsurance,[91] which can lead to cost-related missed treatments, skipped medications, foregone preventive services, and ultimately missed or delayed diagnoses and adverse outcomes.[92, 93] CMS has the opportunity and responsibility to adapt policies to continue to make coverage across all programs more affordable and available. CMS also has a responsibility to ensure that every individual served by the Agency can get the care they need at a provider to whom they can travel, who will serve them, and who they are comfortable with.

This means understanding what may be causing disparities in coverage and then addressing gaps related to health insurance network adequacy, opportunities to enroll in coverage, affordable, comprehensive coverage options, and provider availability and shortages. These barriers are acutely felt in rural, tribal and other communities that are underserved where there are existing provider shortages and limited coverage options. To achieve health equity, CMS must continue to understand where disparities in coverage and access exist and adjust our policies to optimize health equity.

CMS will continue and deepen our work with Agency experts and external stakeholders to understand the impact of existing and new programs and policies on communities that are underserved. We recognize that the best ideas and approaches for how to tackle health disparities will come from voices and stakeholders, not from CMS. We are committed to partnering with all CMS stakeholders so that health equity — and accountability for closing identified disparities in access, quality and outcomes — is at the forefront of our policy decisions, and at the top of the priority list for every health care provider and health plan. That means working with our partners on evidenced-based interventions targeted at reducing health disparities that hold all partners in the health care system accountable to ensure continued progress on reducing gaps in health equity.

Some examples of this work that are already underway include Medicaid and CHIP encouraging all states to implement the 12-month postpartum coverage option now available and broadly applying a health equity lens to many of the innovative discussions underway with states, including section 1115 demonstrations and other Medicaid funding approaches. In addition, new CMS Innovation Center models will include individuals from populations who are underserved and safety net providers, such as community health centers and disproportionate share hospitals. Across CMS we are taking a whole-person view when investing in appropriate, targeted health equity interventions: identifying areas for reducing inequities at the population level, such as avoidable admissions, and setting targets for reducing those inequities, and considering how to make investments in key populations with especially large disparities in health outcomes including maternal/post-partum health, individuals involved in the justice system, and individuals with housing instability.[94, 95]

Priority 3: Build Capacity of Health Care Organizations and the Workforce to Reduce Health and Health Care Disparities

Health care organizations, including CMS's network of quality improvement contractors, and health care professionals have a direct link to individuals, families, and caregivers. They are able to address disparities in the moment health care services are delivered or supports are extended to a community or individual. They are able to structure care teams and extend health services and supports in ways that can address access barriers and ensure every individual gets care that is right for them, when and where they seek it, including home and community based services. Members of the health care team have a unique role in understanding and addressing many of the social risk factors and unmet social needs that can lead to health and health care disparities. CMS's partnership with health care organizations and the workforce is critical, and together we can drive system-wide change. CMS can help build our collective capacity to meet the needs of those we serve by amplifying best and promising practices, research, and health equity tools and resources. CMS utilizes its broad reach to identify, gather, and disseminate information that can assist organizations, providers, and others in ensuring individuals, families, and caregivers receive the highest quality care and services.

For example, CMS Innovation Center models and demonstrations including the Accountable Health Communities model,[96] Community Health Access and Rural Transformation model,[97] and the CMS OMH Minority Research Grant Program[98] support CMS's efforts to explore and test ways health care can be transformed and delivered in communities that are underserved to reduce disparities. Going forward, the CMS Innovation Center aims to engage providers who have not previously participated in value-based care and ensure that eligibility criteria and application processes do not inadvertently exclude or disincentivize care for specific populations, including patients in communities that are rural and underserved.[99] To improve health care professionals' capacity to provide behavioral health care, through Medicaid and CHIP CMS is committed to partnering with states to bring behavioral health services (both mental health and addiction treatment) up to parity with physical health services. This is an ongoing effort. For example, Medicaid funding was recently awarded to states for community-based mobile crisis intervention services, and we are working towards guidance to all states on how to implement mobile crisis services.[100]

CMS diffuses innovation and learnings from these models and grants across our programs. CMS also shares tools and resources proven to reduce disparities with health care organizations and individual providers. CMS works in collaboration with stakeholders to ensure that health equity is a shared goal and that providers and health care organizations have tools they can use to reduce disparities. Some examples of CMS's communities of learning and outreach tools include: collaboratives with State Medicaid Agencies and health plans, technical advisory groups with communities that are underserved such as the Tribal Technical Advisory Group,[101] affinity groups with quality improvement stakeholders, learning and action networks with individual providers and organizations, State Medicaid Director Letters,[102] Health Plan Management System[103] memos, and Medicare Learning Network® educational resources,[104] Annual Letters to Issuers in the Federally-facilitated Exchanges,[105] Disability Competent Care Training Resources,[106] and Technical Assistance Resources for Marketplace stakeholders including the CMS Opportunity to Network & Engage website (CMSzONE) and the Registration for Technical Assistance Portal (RegTAP) Community.[107] Each interaction with a member of a health care team, whether clinical, behavioral, social, or administrative, is another opportunity to make someone's health care, and health status, better. However, health care professionals across settings must be equipped with resources and knowledge of what works to reduce disparities. Each organization and team must establish their shared vision of health equity in order to shift from addressing health issues in silos to an embedded approach that drives improvements and closes gaps in access, quality, and outcomes among specific populations.[108]

For Example: The CMS Health Equity Technical Assistance Program helps health care organizations ready themselves to systematically take action to address health and health care disparities. Health Equity Technical Assistance includes: personalized coaching and resources to help embed health equity into a strategic plan; help with data collection and analysis; and help developing a language access plan and ensuring effective communication with individuals, families and caregivers.

CMS's leading role in quality improvement and focus on health equity can help health care organizations bring their goals into focus. CMS can also help organizations embed health equity in their programs to reduce disparities. CMS's unique partnership and ongoing communication with federal, state, territorial, tribal, local governments, quality improvement networks, health plans, health systems, providers, and community partners allows the Agency to promote validated approaches to reducing disparities. This includes bridging federal resources from across HHS and to the health care settings and communities where they can be most useful. The CMS Health Equity Technical Assistance Program[109] is a cornerstone of our work in this area. This program provides a pathway for CMS stakeholders to receive individually tailored coaching and curated resources from CMS experts. One element of this technical assistance is the CMS Disparities Impact Statement.[110] This tool helps organizations embed equity into their policies, programs, and quality improvement initiatives.

CMS will continue to focus on identifying and promoting promising approaches to reduce disparities. This includes approaches to health care delivery that address barriers to access and health care services such as workforce shortages and network coverage, which can heavily impact communities that are underserved, including rural areas, tribal communities and other communities who have experienced structural and historical inequities. This also includes quality improvement tools to identify and reduce disparities and resources tailored to communities, which can be applied across CMS programs to build the capacity of health care organizations and the workforce.

Priority 4: Advance Language Access, Health Literacy, and the Provision of Culturally Tailored Services

Language access, health literacy, health insurance literacy, and the provision of culturally tailored services play a critical role in health care quality, patient/consumer safety, and experience, and can impact health outcomes and enrollment in coverage.[111, 112, 113, 114, 115] Research indicates that people with limited English proficiency and low health literacy report poor health status nearly twice as much as those without these barriers.[116] Nearly nine percent of the U.S. population are persons with limited English proficiency[117] and nearly 36 percent have low health literacy.[118] Language, health and health insurance literacy, and culture can either promote or inhibit effective communication.

This can have an impact on quality of care, clinical outcomes, diagnosis and management of health conditions, hospital stays, and rates of readmission. Failure to address language, health literacy, and culture can result in patient safety and adverse events including diagnostic errors, missed screenings, and inappropriate care transitions.[119, 120, 121, 122, 123] For example, effectively addressing mental health disparities among American Indians and Alaska Natives requires understanding healing, locally relevant coping strategies, and treatment that is consistent with cultural beliefs and practices within this community.[124] Further, insurance status seems to correlate with health literacy status as well. Individuals with Medicaid are at increased risk of low health literacy.[125] Medicare-enrolled individuals with low health literacy experience increased hospital admissions and visits to emergency departments,[126] as well as higher medical costs[127] and lower access to care.[128] CMS stakeholders continue to emphasize that CMS should consider language, literacy, and cultural aspects if they wish to improve health outcomes and increase enrollment in health care coverage. Stakeholders consistently request best practices and examples of ways to tailor health care services to meet the needs of their communities. One way CMS addresses this within the Health Insurance Marketplaces is through the Navigator program.[129] Navigators play a vital role in helping consumers understand and enroll in the right health care plan that meets their financial and health care needs. They also provide outreach and education to local communities and can help link people to consumer assistance programs[130] as well as appeals programs[131] and ombudsmen[132] to help resolve complaints.

For Example: CMS works to develop and advance resources and tools tailored to the communities we represent, including having Medicare[133] and Marketplace[134] materials available in multiple languages. This attention to communication and cultural needs and health literacy levels equips consumers with the information they need to make informed health coverage choices. These tailored resources and tools include: quality improvement, frameworks and plans, toolkits, and guides to meet many of the unique needs of specific populations.

Each person CMS serves should receive effective, understandable, and respectful care that is responsive to their preferred languages or dialects, health literacy, cultural health beliefs and practice, traditions, and other communication needs.[135, 136] The ideas people have about health, the languages they use, the health literacy skills they have, and the contexts in which they communicate about health, reflect their cultures. Organizations can increase communication effectiveness when they recognize and bridge cultural differences that may contribute to miscommunication.[137] Further, CMS and our partners can improve information available to individuals about their providers' language skills, helping to ensure a person can find a health care professional who can communicate with them in a way they understand. This results in informed shared decision making among providers, patients, and their families and support networks, higher quality of care, better health outcomes, and reduced disparities.[138, 139, 140]

Across our programs and health care settings, we seek to increase the provision of linguistically and culturally appropriate care. To improve equity in health care quality, CMS will continue to identify language, health literacy, and cultural needs among those we serve across different care settings, and strive to meet those needs. Three such examples of this work are the Coverage to Care initiative,[141] the 2020 CMS #FightFlu campaign,[142] and the Disability-Competent Care Training Resources.[143] Through these efforts and others, CMS works with communities that are underserved to identify the challenges and barriers individuals, families, and caregivers experience in accessing care and coverage. We develop culturally tailored resources to meet the needs of those we serve, translate products into multiple languages, and bring messages into our communities by sharing them with trusted local partners. This ensures that information is delivered in ways individuals, families, and caregivers can understand and that resources are widely available for use by providers, other stakeholders, and local trusted partners. This can be particularly important in communities in which individuals speak languages other than English, have ranges of health literacy, or have cultural traditions or values that influence perspectives on health and health care. It also helps build promising practices within our own programs. With over 170 million individuals served by CMS, we have a powerful role in strengthening and enhancing efforts across the health care system to improve access to culturally and linguistically tailored, health literate care and services for our increasingly diverse population.[144]

Priority 5: Increase All Forms of Accessibility to Health Care Services and Coverage

Accessibility is essential to obtaining necessary and appropriate care and services, particularly for people with disabilities. The CDC estimates that 1 in 4 American adults has some form of disability, including related to mobility, cognition, independent living, hearing, vision, and self-care.[145, 146] Rates of disability increase with age, with 2 in 5 adults over age 65 reporting a disability. These rates are higher among racial and ethnic minorities.[147, 148] Individuals with disabilities are more likely to experience higher rates of chronic conditions, including obesity, heart disease, and diabetes. They may be more susceptible to infectious diseases such as COVID-19, than individuals without disabilities.[149, 150] In addition, emergency and disaster readiness efforts must ensure that plans are disability-inclusive and state health agencies, health care organizations, and communities are collaborating

to understand the barriers individuals with disabilities may face during an emergency. This includes preparing for, mitigating, and overcoming challenges together so that disparities are not caused or worsened.[151]

CMS has a responsibility to ensure that individuals and families are able to access health care services when and where they need them in a way that meets individuals' needs and preferences. One prominent challenge for people with disabilities is overcoming barriers to entering and navigating health care information and facilities. People with disabilities may face communication barriers as well as physical barriers, including inaccessible entrances, hallways, signage, information shared during a health care visit, medical equipment, and restrooms.[152, 153] Health care organizations and providers can meet the needs of each person who seeks care by systematically assessing the accessibility of their services for individuals with disabilities. This includes: making infrastructure improvements, strengthening training for providers and staff, and ensuring services are designed to meet the needs of each person they serve, and when appropriate, considering the role of families and caregivers who may be critical to the success of a health care encounter, interaction with a member of the care team, or treatment plan.

CMS has a key role in increasing awareness of the barriers individuals with disabilities face in accessing care. CMS can also help reduce barriers to accessible health care and services by working with health care professionals and individuals with disabilities. Researchers and stakeholders have identified a need to better enforce health care-related accessibility requirements.

They have also noted a need to collect data from health care professionals on accessibility. CMS can address these gaps, including aligning data collection with the 2011 HHS Data Standards[154] which includes physical, communication, cognitive, and functional elements of disability. CMS can also ensure monitoring and oversight of civil rights protections. CMS will continue to provide technical assistance to health care organizations on accessibility requirements. This includes supporting Medicare Advantage plans by providing technical assistance through health plans management system notices, including frequently asked questions with respect to section 504 requirements, ensuring that Medicare Advantage plans attest to accessibility through a checklist each year, and supporting other CMS efforts to advance health equity and eliminate disparities.[155] We will continue to develop training for health care professionals on disability-competent care, and work with health care organizations to increase awareness of programs for people with disabilities. This includes programs such as Medicaid programs for individuals who need help with Activities of Daily Living,[156] Home and Community Based Services (HCBS),[157] and Disability Competent Care Training Resources.[158] For example, CMS is currently supporting state investments to improve local HCBS services and begin investment in needed structural changes. We will continue to work with Congress and other federal partners to advance HCBS improvement and reform and to make continued investments in this area.[159] CMS will continue to engage with stakeholders to understand persistent and emerging accessibility barriers to the provision of health care services and coverage and strengthen opportunities for people with disabilities to receive accessible, equitable care.

For Example: Across CMS, components strive to ensure that all aspects of our programs are accessible to those we serve. CMS convenes federal partners, people with disabilities, and community-serving organizations to understand their perspective on barriers and opportunities for individuals with disabilities. Informed by this input, we develop training curriculum and resources, including the Medicare-Medicaid Coordination Office's Resources for Integrated Care for Health Plans and Providers[160] to help support providers and plans in delivering disability-competent and accessible care.

Conclusion

CMS is committed to placing health equity at the center of our work. Through the priority areas described in this Framework, CMS will examine health inequities to identify and address drivers of disparities. CMS must lead by example, working with health care organizations and the individuals we serve to develop and refine our initiatives, including focusing on overcoming health disparities, eliminating structural barriers that underlie our health system, and forward-planning across all CMS programs to advance health equity.

CMS has a pivotal role to play across every health care setting in every community. However, to achieve the greatest impact, we must work together with our partners and stakeholders such as health care and service providers, health systems, health plans, federal, state, territorial, tribal, local partners, quality improvement networks, individuals, family members, caregivers, patient advocates, health professional organizations, and community partners. We will need each of our partners to commit with us to to meet our shared goal: that all individuals we serve, including members of racial and ethnic communities, people with disabilities, members of the LGBTQ+ community, individuals with limited English proficiency, members of rural communities, and persons otherwise adversely affected by persistent poverty or inequality, realize their highest level of health and well-being, and that we have eliminated disparities in health care quality, access, and outcomes.

Appendix: Foundation for Planning

This section describes the development process for the *CMS Framework for Health Equity*.

FIGURE 1: CMS FRAMEWORK FOR HEALTH EQUITY DEVELOPMENT AND EVOLUTION

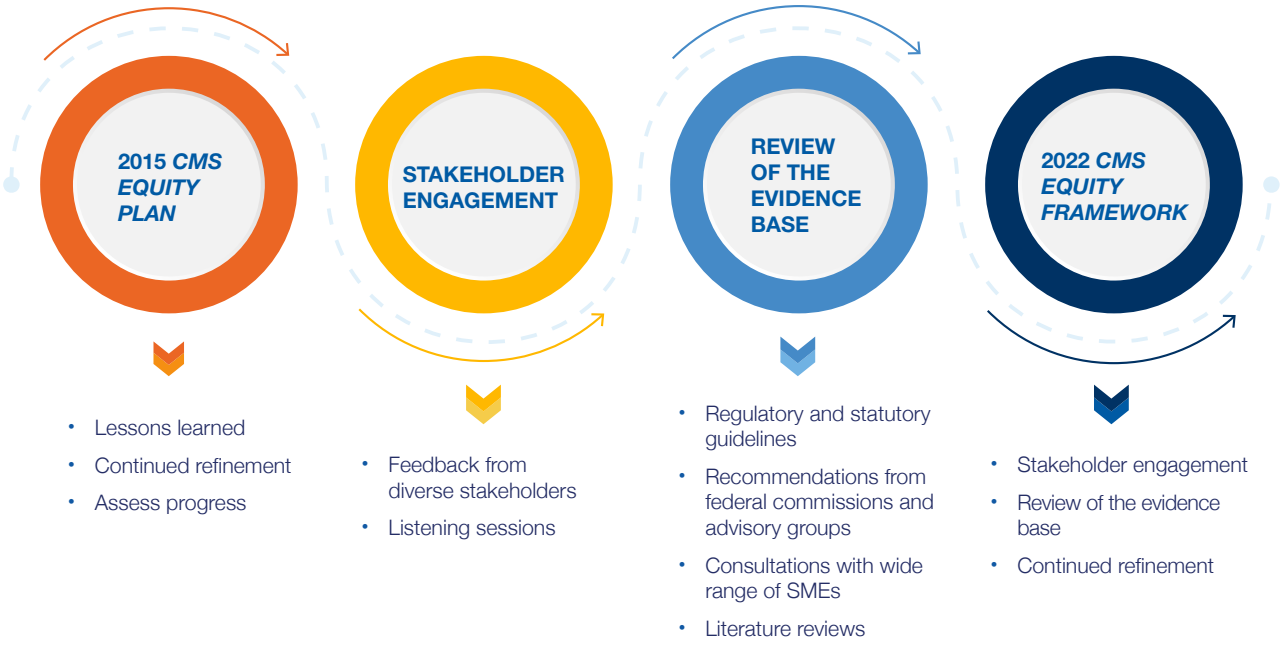


Figure 1 illustrates our process to establish the *CMS Framework for Health Equity*. It begins with the 2015 *CMS Equity Plan for Improving Quality in Medicare* and carries the plan forward through continuous stakeholder engagement, review of the evidence base, and into the updated *CMS Framework for Health Equity* we are now initiating.

2015 CMS Equity Plan for Improving Quality in Medicare

In 2015, CMS issued its first strategic approach to embedding health equity in programs and policies: The *CMS Equity Plan for Improving Quality in Medicare*.[161] This strategy plan outlined our five-year approach to advance health equity in the Medicare program. Over the past several years, CMS has built on existing work done by the Agency as well as external partners. We added new areas of focus to increase understanding of disparities, developed and shared solutions to reduce disparities, and promoted sustainable actions to achieve health equity across the Agency and among our partners. CMS's progress under the *CMS Equity Plan for Improving Quality in Medicare* is described in *Paving the Way to Equity: A Progress Report (2015-2021)*.[162]

The development of the first *CMS Equity Plan for Improving Quality in Medicare* drew heavily on the evidence base and the perspectives of internal and external experts. These experts included: representatives from health care organizations of all types, providers in diverse settings and communities, quality improvement organizations and networks, health insurance and drug plans, integrated health systems, health equity researchers and policy experts, health educators, and individuals from communities that are underserved (e.g., members of racial and ethnic communities, people with disabilities, members of the LGBTQ+ community, individuals with limited English proficiency, and members of rural and tribal communities). To ensure all of these voices were collected, CMS OMH hosted a series of listening sessions designed to seek insight into:

- Significant disparities in health care quality, and the drivers of those disparities;
- Barriers to implementing successful strategies to reduce disparities;
- Promising practices not yet reflected in the published literature;
- Opportunities for CMS to accelerate equity action; and
- Potential partners for CMS to advance this goal.

Stakeholder Engagement and Review of the Evidence Base

Since the initial release of the *CMS Equity Plan for Improving Quality in Medicare* in 2015, CMS has continued and intensified our stakeholder engagement with our initial partners. We have also expanded to new areas. This includes, but is not limited to, additional teams and workgroups within CMS and external stakeholders such as managed health care organizations, State Medicaid Agencies and state and local health departments, representatives of individuals and organizations representing specific health conditions, provider groups, health care settings, and community partners providing social supports and services. We have continuously reevaluated the evidence base, assessed and incorporated new literature, and updated regulatory and statutory guidelines. We have also identified emerging areas of opportunity to drive progress in health equity and to reduce disparities across CMS programs on an ongoing basis.

In 2019, we sought to broaden the existing plan to all CMS programs. We revisited the evidence base, taking a detailed inventory of recommendations and feedback CMS has received through federal commissions and advisory committees including but not limited to: the Medicare Payment Advisory Commission (MedPAC), the Medicaid and CHIP Payment and Access Commission (MACPAC), the Health Equity Task Force for Delivery & Payment Transformation, the National Council on Disability Report, the National Quality Forum Roadmap for Promoting Health Equity and Eliminating Disparities, and the National Academies of Science, Engineering, and Medicine. We also assessed opportunities and recommendations yielded through stakeholder associations

and consumer representatives, including those given at CMS Quality Conferences and other CMS forums and listening sessions, updated published literature, promising practices from the field across diverse settings and communities, and public feedback related to key regulatory and statutory areas of CMS programs including Medicare, Medicaid, CHIP, and the Health Insurance Marketplaces.

From 2020 through 2022, CMS again conducted a series of listening sessions with stakeholders who are driving health equity across all CMS programs. We probed participants for their perspective on current pressing and emerging disparities, and their drivers, across each of CMS's core programs. We also sought insight into the unique barriers, challenges, and opportunities that specific communities that are underserved face related to CMS functions. This included areas for further exploration and opportunities to improve health care access, data and measurement, quality improvement and payment, and health equity-related technical assistance. Stakeholders noted pressing disparities across health conditions. They discussed concerns specific to communities that are underserved including members of racial and ethnic communities, people with disabilities, members of the LGBTQ+ community, individuals with limited English proficiency, members of rural communities, and persons otherwise adversely affected by persistent poverty or inequality. They also highlighted the important link between SDOH, social risk factors and unmet social needs, and health and health care disparities. During these listening sessions, CMS heard detailed feedback related to data collection and stratification for demographic and SDOH data, barriers and opportunities in reimbursement and benefit design, CMS quality improvement initiatives, ideas for training and technical assistance, and considerations for working with trusted partners.

In addition, since the inception of the initial *CMS Equity Plan for Improving Quality in Medicare* and on a continuous basis, we have engaged with federal and CMS experts, teams, and workgroups. We have sought — and continue to seek — ideas around areas of opportunity, improvement, and collaboration. This input and feedback on our activities from the individuals and groups driving progress and improvement in health equity across CMS program areas and core functions brings an Agency-wide perspective to the *CMS Framework for Health Equity* and will continuously inform our work.

Centers for Medicare & Medicaid Services, *The CMS Framework for Health Equity (2022-2032)* (2022).

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