TAHOE FOREST HOSPITAL DISTRICT

2019-02-21 Board Quality Committee Meeting

Thursday, February 21, 2019 at 10:00 a.m.

Tahoe Forest Hospital - Eskridge Conference Room

10121 Pine Avenue, Truckee, CA 96161

Meeting Book - 2019-02-21 Board Quality Committee Meeting

Agenda Packet Contents

TAHOE FOREST HOSPITAL DISTRICT

QUALITY COMMITTEE
AGENDA

Thursday, February 21, 2019 at 10:00 a.m.
Eskridge Conference Room, Tahoe Forest Hospital
10121 Pine Avenue, Truckee, CA

1. CALL TO ORDER

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

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

4. INPUT – AUDIENCE
This is an opportunity for members of the public to address the Committee on items which are not on the agenda. Please state your name for the record. Comments are limited to three minutes. Written comments should be submitted to the Board Clerk 24 hours prior to the meeting to allow for distribution. Under Government Code Section 54954.2 – Brown Act, the Committee cannot take action on any item not on the agenda. The Committee may choose to acknowledge the comment or, where appropriate, briefly answer a question, refer the matter to staff, or set the item for discussion at a future meeting.

5. APPROVAL OF MINUTES OF: 08/09/2018 ..... **ATTACHMENT**

6. ITEMS FOR COMMITTEE DISCUSSION AND/OR RECOMMENDATION

6.1. Safety First

6.2. Quality Committee Charter..... **ATTACHMENT**
Board Quality Committee Charter was approved on November 30, 2017 and is available for reference.

6.3. Quality Assurance/Process Improvement Plan ..... **ATTACHMENT**
Committee will review the 2019 QA/PI Plan, discuss the priorities for 2019, and recommend approval to the full BOD.

6.4. Patient & Family Centered Care

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

6.4.2. TFHD PFAC Video
Committee will review PFAC video highlighting the program at TFHD.

6.5. Patient Safety

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

6.5.2. High Reliability Organization (HRO)
Committee will receive a status report on HRO education and next steps.

6.5.3. Low Volume Policy (MSCP-11) .....ATTACHMENT
Committee will receive an update on the plan for Medical Staff to review the policy and follow up with the board.

6.6. TFHD Quality Website.....ATTACHMENT
Quality Committee will review the draft Tahoe Forest Hospital District (TFHD) website quality page and provide input.

6.7. Performance Excellence Boards
Quality Committee will review new performance excellence board quality metrics.

6.8. Board Quality Education .....ATTACHMENT
The Committee will review the educational article listed below and discuss topics for future board quality education.

6.8.1. *California Future Health Workforce Commission (2019) Executive Summary: Meeting the Demand for Health.*

7. REVIEW FOLLOW UP ITEMS / BOARD MEETING RECOMMENDATIONS

8. NEXT MEETING DATE
The date and time of the next committee meeting, Tuesday, May 14, 2019 at 12:00 p.m. will be confirmed.

9. ADJOURN

*Denotes material (or a portion thereof) may be distributed later.

Note: It is the policy of Tahoe Forest Hospital District to not discriminate in admissions, provisions of services, hiring, training and employment practices on the basis of color, national origin, sex, religion, age or disability including AIDS and related conditions.

Equal Opportunity Employer. The meeting location is accessible to people with disabilities. Every reasonable effort will be made to accommodate participation of the disabled in all of the District's public meetings. If particular accommodations for the disabled are needed (i.e., disability-related aids or other services), please contact the Executive Assistant at 582-3481 at least 24 hours in advance of the meeting.

BOARD QUALITY COMMITTEE
DRAFT MINUTES

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

1. CALL TO ORDER
Meeting was called to order at 12:00 p.m.

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

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

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

4. INPUT – AUDIENCE
No public comment was received.

5. APPROVAL OF MINUTES OF: 08/09/2018
Director Zipkin moved approval of the August 9, 2018 Board Quality Committee minutes, seconded by Director Wong.

6. ITEMS FOR COMMITTEE DISCUSSION AND/OR RECOMMENDATION

6.1. Safety First
Dr. Taylor presented Safety First about the importance of using SBAR (Situation, Background, Assessment, Recommendation) as a communication tool.

Karen Baffone, Chief Nursing Officer and Dr. Shawni Coll, Chief Medical Officer, joined at 12:03 p.m.

CNO stated SBAR is a best practice in healthcare and yes, the hospital uses it. Senior leaders would like staff to use SBAR all of the time as they want consistency in the way communication is handled between providers, regardless of who the providers are.

Users are reminded to be concise and to the point.

6.2. Patient & Family Centered Care (PFCC)

6.2.1. Follow up from Patient Experience Presentation
Quality Committee received an update on Mental Health coordination and resources for patients in our community.

CNO is gearing up to present to the board on mental health on November 29.

Mark Cross, a Psych PA, is here full time working in a variety of settings: inpatient, outpatient, and

Emergency Room.

Director Zipkin asked what the scope of his license was. CEO noted he can do a lot of work and can order prescriptions. CMO added there is a 5% chart review for all Physician Assistants and any narcotics prescriptions have to be reviewed within seven days. Dr. Gail Pritchard is reviewing more of his charts initially and working on one on one mentoring.

A book of mental health resources was published by the Wellness Neighborhood.

The main point of bringing in a psychiatric Physician Assistant was to get referrals handled within 24 hours.

6.2.2. Patient & Family Advisory Council Update

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

Lorna Tirman, Patient Experience Specialist, stated the PFAC will meet one more time this year.

The PFAC most recently reviewed the quality website and it was a very engaged meeting. The public wanted drop downs and information presented in accessible fashion.

Judy Newland, Chief Operations Officer, joined at 12:22 p.m.

They were looking to make the website overall more user friendly. The PFAC noted there was too much information.

Director of Quality shared that Hospital Quality Institute (HQI) recognized Tahoe Forest for the quality content shared.

Patient Experience Specialist is working on scripting regarding patient experience surveys. She is also working with the Chief Human Resources Officer (CHRO) on customer service education. There are keywords that will help to keep consistency as well as specific behaviors to hire to and coach to.

Item 6.5. was reviewed next.

6.5. Complaint/Grievance Policy

Patient Experience Specialist provided an overview of the Compliant/Grievance Policy (AGOV-24).

Generally, a complaint is made, usually while the patient is here. Service recovery is attempted.

A grievance is anything in writing about a patient's care, not billing related. The Patient Experience Specialist will reach out and has to respond in writing in 7-30 days. If it cannot be taken care of with the provider then the matter will be taken to the Grievance Committee which is made up of Dr. Peter Taylor, Matt Mushet, Vicki Morgan, Janet Van Gelder, Risk Manager and any subject matter experts needed,

Director of Quality noted that CMS requires the District to follow up on all quality of care matters.

CEO added that the goal is to allow the Patient Experience Specialist to focus on care complaints.

Director Zipkin asked if item H on page 19 of the packet means the resolution will not be presented to the board. Patient Experience Specialist stated the Board delegated resolution to the Grievance Committee. The Board will hear if the patient files a claim.

Director of Quality will go through the Department Chair to determine peer review.

The policy was changed so that Patient Experience Specialist works directly with providers and staff instead of forwarding the complaint to the provider.

COO noted the District has had a lot of success having clinical person manage complaint process.

6.3. Patient Safety

6.3.1. BETA HEART Program

Quality Committee received an update regarding the BETA Healthcare Group's Culture of Safety program.

BETA mandates the District uses the SCORE (Safety, Communication, Operational Reliability, and Engagement) Culture of Safety survey. The board received a high level overview of the survey.

Zipkin is the board going to see the results
Showed weaknesses on a slide.
Board members didn't feel the presentation was clear.

Director of Quality shared a draft BETA HEART (Healing, Empathy, Accountability, Resolution and Trust) program progress report. Five domains were highlighted: Culture of Safety, Rapid Event Response & Analysis, Communication & Transparency, Care for the Caregiver, and Early Resolution.

Director Zipkin inquired what a 2% premium reduction amounts to. The total reduction in premiums is 10% (2% for each domain) which is around $100,000 in savings. BETA will come every year to check that the District is meeting the criteria.

6.3.2. BETA Quest for Zero Harm Recognition

Quality Committee reviewed the recognition for BETA Healthcare Group's Quest for Zero program in Obstetrics and Emergency Care at Tahoe Forest Hospital and Incline Village Community Hospital.

6.4. Hospital Compare Star Rating

The committee received an update on the Hospital Compare star rating program. This is the quality star rating that has been shared with the public by CMS.

Discussion was held about the core measures that are used in the rating.

Care coordination is now the main focus. Tahoe Forest's readmission rate is lower than the national average.

The Hospital Compare website will be updated in December.

The District has three Suboxone certified providers.

6.6. Board Quality Education

The Committee reviewed and discussed the CMS Rural Health Strategy (2018) retrieved June 7, 2018 from *https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Rural-Strategy-2018.pdf*

Rural Health Clinics (RHC) are a foundational piece to the District's future.

Brief discussion was held on the rural health strategy across America. If the Federal Government does not solve the Medicaid issue, rural hospitals will drop like flies.

The article was well presented.

7. REVIEW FOLLOW UP ITEMS / BOARD MEETING RECOMMENDATIONS

None.

8. NEXT MEETING DATE

The date and time of the next committee meeting will be confirmed once the committee assignments are made.

9. ADJOURN

Meeting adjourned at 1:20 p.m.

Charter

Quality Committee
Tahoe Forest Hospital District
Board of Directors

PURPOSE:

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

RESPONSIBILITIES:

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

DUTIES:

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

COMPOSITION:

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

MEETING FREQUENCY:

The Committee shall meet quarterly.

TAHOE FOREST HEALTH SYSTEM

Origination Date:	*N/A*
Last Approved:	*N/A*
Last Revised:	*N/A*
Next Review:	*N/A*
Department:	*Quality Assurance / Performance Improvement - AQPI*
Applies To:	*System*

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

PURPOSE:

The purpose of the Quality Assurance/Performance Improvement (QA/PI) plan is to provide a framework for promoting and sustaining performance improvement at Tahoe Forest Health System, in order to improve the quality of care and enhance organizational performance. The goals are to proactively reduce risk to our patients by eliminating or reducing factors that contribute to unanticipated adverse events and/or outcomes and provide high quality care and services to ensure a perfect care 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 use of the Just Culture model 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 used to guide all improvement activities.

POLICY:

MISSION STATEMENT

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

VISION STATEMENT

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

VALUES STATEMENT

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

A. Quality – holding ourselves to the highest standards and having personal integrity in all we do.

B. Understanding – being aware of the concerns of others, caring for and respecting each other as we interact.

C. Excellence – doing things right the first time, on time, every time; and being accountable and responsible.

D. Stewardship – being a community steward in the care, handling and responsible management of resources while providing quality health care.

E. Teamwork – looking out for those we work with, findings ways to support each other in the jobs we do.

FOUNDATIONS OF EXCELLENCE

A. Our foundation of excellence includes: Quality, Service, People, Finance and Growth.

1. Quality – provide excellence in clinical outcomes
2. Service – best place to be cared for
3. People – best place to work, practice, and volunteer
4. Finance – provide superior financial performance
5. Growth – meet the needs of the community

PERFORMANCE IMPROVEMENT INITIATIVES

A. The 2019 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. Perfect Care Experience
2. Sustain a Just Culture philosophy that promotes a culture of safety, transparency, and system improvement
    a. Participate in Beta HEART (healing, empathy, accountability, resolution, trust) program
    b. Continued focus on the importance of event reporting
3. Ensure Patient Safety across the entire Health System with a focus on 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
4. 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.

5. Identify and promote best practice and evidence-based medicine
6. Promote lean principles to improve processes, reduce waste, and eliminate inefficiencies
7. Identify gaps in the Epic electronic health record system upgrade and develop plans of correction
8. Maximize Epic reporting functionality to improve data capture and identification of areas for improvement

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

ORGANIZATION FRAMEWORK

Processes cross many departmental boundaries and performance improvement requires a planned, collaborative effort between all hospital-based departments, services, and outside Tahoe Forest Health System, 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 *(See Attachment B – CAH Services)*. The BOD assures that a planned and systematic process is in place for measuring, analyzing and improving the quality and safety of the Health System activities.

B. The Board:

1. Delegates the authority for developing, implementing, and maintaining performance improvement activities to administration, medical staff, management, and employees;
2. Recognizes that performance improvement is a continuous, never-ending process, and therefore they will provide the necessary resources to carry out this philosophy;
3. Provides direction for the organization’s improvement activities through the development of strategic initiatives;
4. Evaluates the organization’s effectiveness in improving quality through reports from the various

board committees, Medical Executive Committee and Medical Staff Quality Committee.

Administrative Council

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

B. Administrative Council has developed a culture of safety by embracing the Just Culture model and has set behavior expectations for providing no less than Safe, Timely, Effective, Efficient, Equitable, Patient Centered Care (STEEEP^{TM}). y ensure compliance with regulatory, statutory and contractual requirements.

Board Quality Committee

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

Medical Executive Committee

A. The Medical Executive Committee shares responsibility with the BOD Quality Committee and senior management 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 and Focused Professional Performance Evaluation 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. 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.

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

Hospital Management (Directors, Managers, and Supervisors)

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

1. Foster an environment of collaboration and open communication with both internal and external customers;
2. Participate and guide staff in the patient advocacy program;
3. Advance the philosophy of Just Culture 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 as recommended by the Just Culture model and implement changes to reduce the probability of such events in the future.

Employees

A. The role of the individual employee is critical to the success of a performance improvement initiative. Quality is everyone’s responsibility and each employee is charged with practicing and supporting the Standards of Business Conduct: Health System Code of Conduct and Chain of Command for Medical Care Issues policies. All employees must feel empowered to report, correct, and prevent problems.

B. The Nursing Quality and Peer Review Council consist of registered nurses from each service area. This Council is an integral part of reviewing QA/PI data, evaluating processes, providing recommendations, and communicating their findings with peers to improve nursing practice.

C. Employees are expected to do the following:

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

PERFORMANCE IMPROVEMENT STRUCTURE

Medical Staff Quality Assessment Committee

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

The Medical Staff Quality Assessment Committee:

A. Annually review and approve the Medication Error Reduction Plan (MERP), Infection Control Plan, Environment of Care Management Program, Utilization Review Plan, Risk Management Plan, and the Patient Safety Plan.
B. Regularly reviews progress to the aforementioned plans.
C. Reviews quarterly quality indicators to evaluate patient care and delivery of services and takes appropriate actions based on patient and process outcomes;
D. Reviews recommendations for performance improvement activities based on patterns and trends identified by the proactive risk reduction programs and from the various Health System committees;
E. Elicits and clarifies suspected or identified problems in the provision of service, quality, or safety standards that may require further investigation;
F. Reviews and approves chartered Performance Improvement Teams as recommended by the Performance Improvement Committee (PIC). Not all performance improvement efforts require a chartered team;
G. Reviews progress reports from chartered teams and assists to address and overcome identified barriers;
H. Reviews summaries and recommendations of Event Analysis/Root Cause Analysis (RCA) and Failure Mode Effects Analysis (FMEA) activities.
I. Oversees the radiation safety program, including nuclear medicine and radiation oncology and evaluates the services provided and make recommendations to the MEC.

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

B. The Performance Improvement Committee will:

1. Oversee the Performance Improvement activities of TFHS including data collection, data analysis, improvement, and communication to stakeholders
2. Set performance improvement priorities and provide the resources to achieve improvement
3. Reviews requests for chartered Performance Improvement Teams. Requests for teams may come from committees, department or individual employees. Not all performance improvement efforts require a chartered team;
4. Report the committee's activities quarterly to the Medical Staff Quality Committee.

SCIENTIFIC METHOD FOR IMPROVEMENT ACTIVITIES

Tahoe Forest Health System utilizes DMAIC Rapid Cycle Teams (Define, Measure, Analyze, Improve, Control). The BOD, Administrative Council Members, 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 BOD, Administrative Council Members, or MS QAC
2. Establish specific, measurable goals and monitoring for identified initiatives
3. Utilize lean principles to improve processes, reduce waste, and eliminate inefficiencies
4. Report their findings and recommendations to key stakeholders, PIC, and the MS QAC.

PERFORMANCE IMPROVEMENT EDUCATION

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

B. A select group of employees have received specialized facilitator training in using the DMAIC rapid cycle

process improvement and utilizing statistical data tools for performance improvement. These facilitators may be assigned to chartered teams at the discretion of the PIC, MS QAC and Administrative Council Members. Staff trained and qualified in Lean/Six Sigma will facilitate the chartering, implementation, and control of enterprise level projects.

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

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

PERFORMANCE IMPROVEMENT PRIORITIES

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

1. Processes that are high risk, high volume, or problem prone areas with a focus on the incidence, prevalence, and severity of problems in those areas
2. Processes that affect patient safety and outcomes
3. Processes related to patient advocacy and the perfect care experience
4. Processes related to the National Quality Forum (NQF) Endorsed Set of Safe Practices
5. Processes related to patient flow
6. Processes associated with near miss Sentinel/Adverse Event/Error or Unanticipated Outcome

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

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

DESIGNING NEW AND MODIFIED PROCESSES/ FUNCTIONS/SERVICES

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

1. Key individuals, who will own the process when it is completed, are assigned to a team led by the responsible individual.

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

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

PROACTIVE RISK ASSESSMENTS

A. Risk assessments are conducted to proactively evaluate the impact of buildings, grounds, equipment, occupants, and internal physical systems on patient and public safety. This includes, but is not limited to, the following:
    1. A Failure Effect Mode Analysis (FMEA) will be completed based on the organization's assessment and current trends in the health care industry and as approved by PIC or the MS QAC.

2. The Medical Staff Quality Committee and other leadership committees will recommend the processes chosen for our proactive risk assessments based on literature, errors and near miss events, sentinel event alerts, and the National Quality Forum (NQF) Endorsed Set of Safe Practices.
    a. The process is assessed to identify steps that may cause undesirable variations, or “failure modes”.
    b. For each identified failure mode, the possible effects, including the seriousness of the effects on the patient are identified and the potential breakdowns for failures will be prioritized.
    c. Potential risk points in the process will be closely analyzed including decision points and patient’s moving from one level of care to another through the continuum of care.
    d. For the effects on the patient that are determined to be “critical”, a 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 complete a written infection control and preconstruction risk assessment for interim life safety for new construction or renovation projects.

DATA COLLECTION

A. Tahoe Forest Health System chooses processes and outcomes to monitor based on the mission and scope of care and services provided and populations served. The goal is 100% compliance with each identified quality metric. Data that the organization considers for the purpose of monitoring performance includes, but is not limited to, the following:
    1. Medication therapy
    2. Infection control surveillance and reporting
    3. Surgical/invasive and manipulative procedures
    4. Blood product usage
    5. Data management
    6. Discharge planning
    7. Utilization management
    8. Complaints and grievances

9. Restraints/seclusion use
10. Mortality review
11. Medical errors including medication, surgical, and diagnostic errors; equipment failures, infections, blood transfusion related injuries, and deaths due to seclusion or restraints
12. 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
13. Resuscitation and critical incident debriefings
14. Performance measures from acceptable data bases/comparative reports, i.e., Quantros, NDNQI, HCAHPS, Hospital Compare, QHi, CAHEN 2.0, and Press Ganey
15. Summaries of performance improvement actions and actions to reduce risks to patients

B. In addition, the following clinical and administrative data is aggregated and analyzed to support patient care and operations:
    1. Quality measures delineated in clinical contracts will be reviewed annually
    2. Pharmacy transactions as required by law and to control and account for all drugs
    3. Information about hazards and safety practices used to identify safety management issues to be addressed by the organization
    4. Records of radio nuclides and radiopharmaceuticals, including the radionuclide's identity, the date received, method of receipt, activity, recipient's identity, date administered, and disposal
    5. Reports of required reporting to federal, state, authorities
    6. Performance measures of processes and outcomes, including measures outlined in clinical contracts
C. These data are reviewed regularly by the PIC, MSQAC, and the BOD with a goal of 100% compliance. The review focuses on any identified outlier and the plan of correction.

AGGREGATION AND ANALYSIS OF DATA

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

B. Data is analyzed in many ways including:
    1. Using appropriate performance improvement problem solving tools
    2. Making internal comparisons of the performance of processes and outcomes over time

3. Comparing performance data about the processes with information from up-to-date sources
4. Comparing performance data about the processes and outcomes to other hospitals and reference databases

C. 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

D. 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 on a quarterly basis. Results of the appraisal of performance measures outlined in clinical contracts will be reported to the MS QAC and Medical Staff annually.

B. The MS QAC will provide their analysis of the quality of patient care and services to the Medical Executive Committee on a quarterly basis. The Medical Executive Committee, Quality Medical Director, or the Director of Quality & Regulations will report to the BOD at least quarterly relevant findings from all performance improvement activities performed throughout the System.

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

CONFIDENTIALITY AND CONFLICT OF INTEREST

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

ANNUAL ASSESSMENT

A. The Quality Assurance program and the objective, structure, methodologies, and results of performance improvement activities will be evaluated at least annually. 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.

B. purpose of the evaluation is to determine whether the utilization of services is appropriate, policies are followed, and needed changes are identified. The Quality Assurance program evaluates the quality and appropriateness of diagnoses, treatments furnished, and treatment outcomes. 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 Assurance Performance Improvement Plan will be reviewed, updated, and approved annually by the Medical Staff Quality Committee, the Medical Executive Committee, and the Board of Directors.

Related Policies/Forms:

Medication Error Reduction Plan, APH-34

Medication Error Reporting, APH-24

Infection Control Plan, AIPC-64

Environment of Care Management Program, AEOC-908

Utilization Review Plan (UR), DCM-1701

Risk Management Plan , AQPI-04

Patient Safety Plan, AQPI-02

References:

HFAP and CMS

All revision dates:	03/2018, 02/2017, 02/2017, 02/2016, 12/2014, 02/2014
Attachments:	A. Quality Initiatives 2018 B. CAH Services by Agreement C. 2018 QA PI Reporting Measures D. QI Indicator Definitions 2018 E. 2018 External Reporting

Beta HEART Program Update for January 2019

HEART = Healing, Empathy, Accountability, Resolution, Trust

Dawn Lockwood, Interim Risk Manager/Patient Safety Officer

- 6 TFHD Staff completed all 3 Beta HEART symposiums in 2018
- 8-10 additional staff planned for training in 2019 beginning in February
- SCORE (*Safety, Communication, Operational Reliability, and Engagement)*
  Culture of Safety Survey 1st round completed in March
  - 64% response rate, with 48 providers
  - Results have been shared with all department leaders and AC. Key areas for opportunity overall included:
    - Teamwork (inter and intra- departmental)
    - Improving feedback and performance expectations to staff (by leadership)
    - Continuing to work on technology process improvement (EPIC)
  - Survey results and debriefing sessions with department staff are occurring throughout July and August
  - Department Leadership has developed goals and are monitoring progress via PIC reporting and DMAIC
- 2nd round of SCORE Culture of Safety Survey planned for March

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

- See progress on attached Beta HEART progress grid

Beta HEART Progress Report as of January 2019

Domain	Incentive/ Renewal Credit	% Completed	Estimated date for completion	Comments
Culture of Safety	2%	90%	April 2019	Part of the validation process involves having 1 year results, which will occur after second SCORE survey in March 2019
Rapid Event Response and analysis	2%	60%	June 2019	Many components in place. Need to formalize several areas including training of additional staff and House Supervisors
Communication and transparency	2%	80%	April 2019	Many components in place. Need to formalize several areas and hard wire timeliness
Care for the Caregiver	2%	60%	June 2019	Many components in place. Need to formalize several areas including additional education to staff.
Early Resolution	2%	50%	September 2019	Many components in place. Need to formalize several areas including hiring and training a new Risk Manager to assist with these cases, when they occur.

TAHOE FOREST HEALTH SYSTEM

Origination Date:	*01/2011*
Last Approved:	*09/2016*
Last Revised:	*09/2016*
Next Review:	*09/2019*
Department:	*Credentialing and Privileging - MSCP*
Applies To:	*Incline Village Community Hospital, Tahoe Forest Hospital*

Low Volume Policy, MSCP-11

SCOPE:

Every initial Medical Staff application and every reappointment application shall be reviewed for several elements regarding clinical activity and competency. There shall be adequate data regarding a practitioner's performance to assess their competence. When there is little or no data on their performance at the organization, the practitioner may be considered a low volume practitioner.

POLICY:

It is the policy of Tahoe Forest Hospital District that, Tahoe Forest Hospital ("TFH") and Incline Village Community Hospital ("IVCH") considers granting practitioners with little or no clinical activity, only those privileges for which adequate evidence of the provider's current competence is provided through the credentialing process. This policy will be pursued in parallel with the goal of building and maintaining productive, collaborative relationships between Tahoe Forest Hospital District and providers in the community whose practice includes little or no volume of clinical care in the hospital setting.

A. The most common type of practitioners who fall into the low volume category are the following.
    1. Active members of the medical staff who primarily practice in an ambulatory surgery setting;
    2. Active members of the medical staff who primarily work in an outpatient practice;
    3. Clinically inactive members of the medical staff who are on a Leave of Absence (LOA) who have taken time off or who retired and wish to return to practice;
    4. Locum tenens practitioners.

B. In accordance with the Medical Staff Bylaws and regulatory standards, relevant elements will be considered for all practitioners to measure clinical competency including but not limited to the following:
    1. Licensure history from primary source verification;
    2. Evidence of continuing medical education every two years;
    3. Medical education and post graduate training;
    4. Malpractice insurance and history for 5 years including claims, settlements and judgments;
    5. Documentation of specialty board status in compliance with established departmental credentialing criteria;
    6. Criminal back ground history;

7. Sanction from Medicare/Medicaid;
8. Actions against DEA certificate or state controlled substances certification;
9. Healthcare employment history;
10. Professional references which include peers of which one shall be an individual with the same specialty or field of practice as the applicant/reappointment applicant familiar with his/her practice of medicine, results of peer review activities, and other sources of information regarding current competence for clinical privileges requested.
11. Clinical activity which includes procedure logs with outcomes to support privileges requested. This includes activity logs with outcomes for applicants with privileges but low volume of work at this facility.
12. National Practitioner Data Bank query and response;
13. For reappointment applicants, peer review data via routine review and quality assurance activity.

PROCEDURE:

A. At the time of appointment and reappointment, the medical staff services office along with the quality and risk department coordinator will compile all the information outlined above and prepare a summary and a profile for review by the department chair;

B. The department chair will review and make a recommendation to the Medical Executive Committee ("MEC");

C. If there is insufficient information, and it is deemed that the provider does not meet the minimum threshold criteria, and the hospital and medical staff leadership has deemed that continued membership is important to provide a needed service at the hospital, the MEC may recommend the following:

1. Information may be requested from another facility including other hospitals or ambulatory surgery centers where the physician practices including volume and outcomes data.
2. In lieu of sufficient activity at any facility, the medical staff leadership will consider one or more of the following:
   - Additional concurrent proctoring;
   - Additional references;
   - Full orientation (full day);.
   - Co management may be implemented until the hospital's proctoring process confirms current competence. Practitioners granted co management privileges are overseen by a physician who assumes ultimate responsibility for the care of such patients. The level and intensity of oversight will be determined on a case by case basis by the Medical Executive Committee upon the recommendation from the Department based on the practitioner's prior training, recent experience, and the patient risk associated with the specific privileges required for co management.
   - May require physician to attend physician assessment program and/or complete additional and ongoing training sufficient to maintain competence.

D. Whenever an application contains insufficient peer review results to assess current clinical competence and the decision regarding a practitioner's privileges depends significantly on information contained in professional references, the department chair or designee will actively participate in personally contacting several of the references and in assessing whether or not the information provided by references is

adequate to establish current competence for the requested privileges. This type of application requires a $500 fee levied to cover the cost of additional evaluation.

E. The burden is always on the applicant to demonstrate competency. There needs to be sufficient information in which to base an appointment or reappointment. This includes assisting the Hospital in obtaining needed information from other settings in which the applicant practices. If information is not provided that is needed to assess current competency for specific privileges, the practitioner's application for those specific privileges will be considered incomplete and will not be processed. The application for privileges for which sufficient information is available will be processed through the Medical Staff's credentialing process.

Related Policies/Forms:
References: TFHD Medical Staff Bylaws; HFAP 03.01.15,CMS, The Joint Commission, Horty Springer Conference, HCPro, -Credentialing Resource Center
Policy Owner: Director, Medical Staff Services.
Approved by: Executive Committee

All revision dates: 09/2016, 01/2014, 01/2013, 01/2012, 01/2011

Attachments:

No Attachments

Approval Signatures

Step Description	Approver	Date
	Harry Weis: CEO	09/2016
Board of Directors	Jean Steinberg: Director, Medical Staff Svs.	09/2016
MEC	Jean Steinberg: Director, Medical Staff Svs.	09/2016
	Jean Steinberg: Director, Medical Staff Svs.	09/2016

QUALITY AND SAFETY

We know you have choices when it comes to your healthcare. And when you choose us, we promise to offer the highest quality care and best experience from the moment you walk in the door. This commitment to you, our friend and neighbor, is what sets us apart from the rest.

Meeting Your Needs through Safe, Timely, Effective, Efficient, Equitable Patient-Centered Care (STEEEP)

We have adopted the Institute of Medicine's framework to deliver quality and patient safety within our hospital district. This framework, called "STEEEP", is aligned with IHI's Triple Aim Initiative. In a nut shell, this initiative sets the agenda for population health, patient experience, and reduced healthcare costs.

Safe – Your safety comes first

Timely – Care will be delivered in the most-timely manner possible

Effective – Care will be based on the best science available

Efficient – Care will avoid waste of money, time and resources

Equitable – Access to care will be provided in an equitable manner

Patient-Centered – Patients will participate fully in care decisions

Recent Awards and Affiliations

We are proud of our many recognitions for high quality in rural health care delivery. Because of our strong focus on quality, performance excellence, innovation and excellent patient care, the Tahoe Forest Health System has been recognized in many different ways. These recognitions and affiliations are from July 2017 to current.

Resuscitation Quality Improvement

Tahoe Forest Hospital received recognition from the American Heart Association and Laerdal for our dedication to high-quality cardiopulmonary resuscitation (CPR). We have officially participated in the Resuscitation Quality Improvement (RQI) program for two years.

RQI data shows that our CPR quality has dramatically increased over the two years now that staff has hands-on practice every three months rather than every two years. Furthermore, we have heard from staff that their confidence in their ability to perform good CPR has increased. The RQI goal is to be in every hospital by 2025 and we are fortunate to be an early adopter of this model.

Smart Care California Primary C-Section Rate

Under the Healthy People 2020 initiative, hospitals are encouraged to reduce rates of elective cesarean deliveries for low-risk, first-time births to less than 23.9 percent. Since 2016, Smart Care California has included hospitals that have achieved that milestone on its hospital honor roll.

For more information, read more here.

America's Best Hospitals for Obstetrics

The Joseph Family Center for Women and Newborn Care was awarded the 2018 Women's Choice Award for America's Best Hospitals for Obstetrics. The award is based on the following criteria:

- The percentage of patients reporting through the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey that they would definitely recommend the hospital,
- Patient safety ranking based on 11 Centers for Medicare and Medicaid Services' (CMS) measures of infection and complication rates ,
- Low rates of early elective deliveries (between 0 - 1%), and
- Baby-Friendly USA designation, a World Health Organization (WHO) /United Nations Children's Fund (UNICEF) initiative to support best practices for breast feeding education and counseling.

Read more here.

Accreditation

Tahoe Forest Hospital and Incline Village Community Hospital are accredited by the Healthcare Facilities Accreditation Program (HFAP), an organization authorized by the Centers for Medicare and Medicaid Services (CMS) to survey all hospitals for compliance with the Medicare Conditions of Participation and Coverage. Find out more about HFAP here.

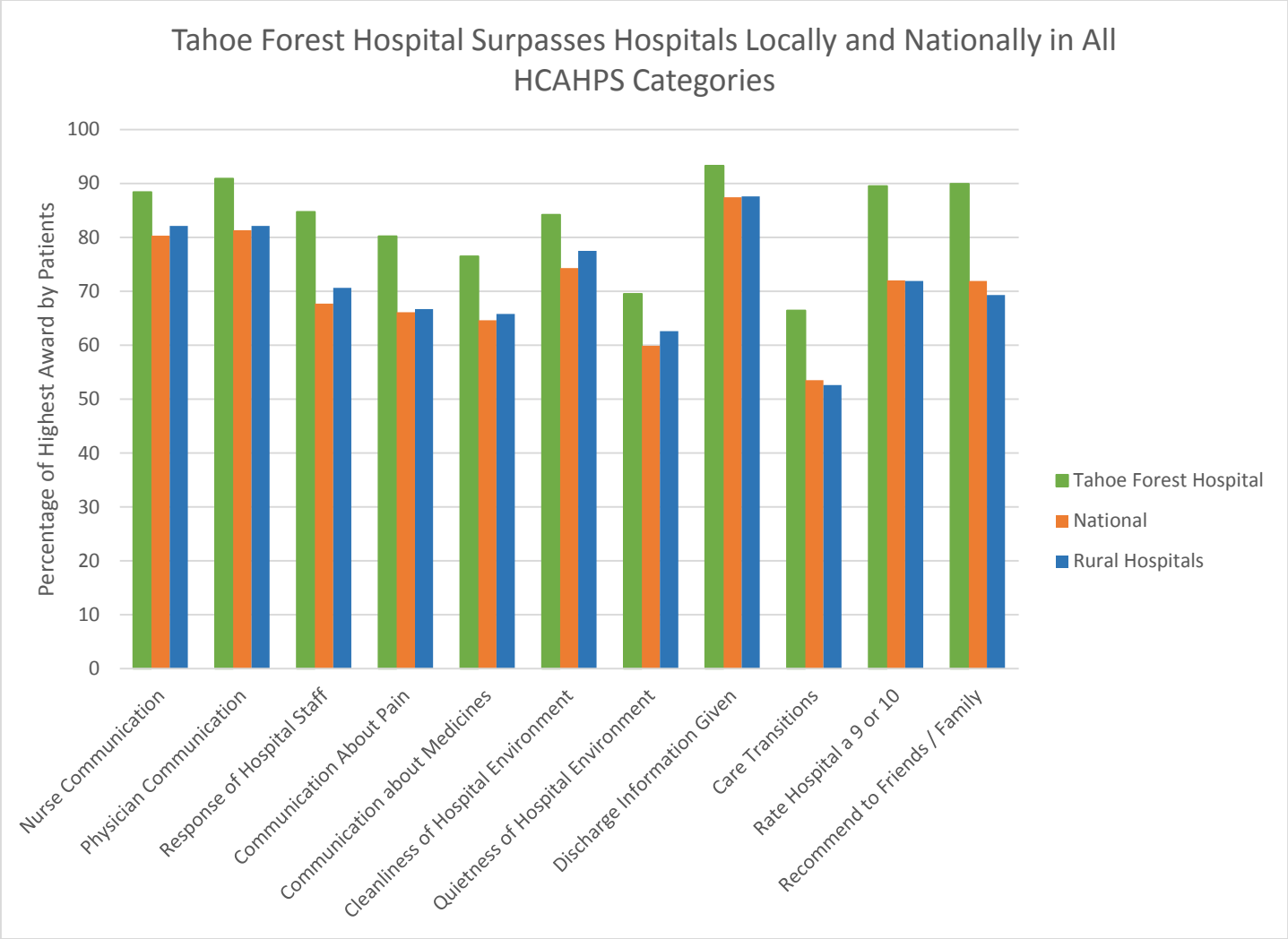
For a complete listing of our recognitions and affiliations, please visit this site.

Patient Satisfaction Ratings and Involvement

HCAHPS

HCAHPS (pronounced "H-caps") stands for the Hospital Consumer Assessment of Healthcare Providers and Systems and defines a core set of patient satisfaction metrics that complement the quality data hospitals collect to support improvements. HCAHPS is the national standard for collecting and publicly reporting information about a patient's experience of care, and allows for valid comparisons to be made across hospitals locally, regionally and nationally.

Tahoe Forest Hospital District is proud to announce that we consistently exceed state and national averages in all categories of patient satisfaction.



Data source is December 2018 Press Ganey data. Reporting period is 01/01/2018 – 12/31/2018. In this context, higher values demonstrate better performance.

You can read more about our overall patient experience here.

Patient Family Advisory Council

Our health system values the perspectives of our patients, families, and communities. As part of our commitment to provide every patient and family with the best experience possible, we have a Patient and Family Advisory Council (PFAC) made up of community volunteers that meets regularly to discuss hospital based operations and how to better serve our community.

If you would like to serve on our Patient and Family Advisory Council, or know of anyone else that may be interested, we would appreciate speaking with you to discuss the important work that this Council does to improve the services at Tahoe Forest Hospital District. You can contact Lorna Tirman:

Lorna Tirman PhD, MHA, RN
Patient Experience Specialist
ltirman@tfhd.com
(530) 582-6567

Person and Family Engagement Metrics

The Center for Medicare & Medicaid Services (CMS) endorse five metrics for Person and Family Engagement (PFE). Here is how we stack up!

PFE Metric	Intent	Criteria	Status	Action Plan
PFE 1: Planning Checklist	Create a mechanism and procedure so that patients and families scheduled for admission are sent a checklist and then have an opportunity to talk with hospital staff members prior to, or at admission.	• Prior to scheduled admission, hospital provides a pre-admission checklist to patient. • Prior to, or during admission, hospital discusses checklist, allowing for questions and comments from the patient or family.	Met	Continue educating physicians, front-line staff, and patients regarding importance of this checklist. Continue refining admit paperwork and process to optimize patient experience and information transfer.
PFE 2: Shift Change Huddles and Bedside Reporting	Include the patient and/or family caregiver in as many conversations about their care as possible throughout the hospital stay.	• In at least one unit, nurse shift change huddles OR clinician reports occur at the bedside and involve the patient and/or family members.	Met	Continue educating physicians, front-line staff, and patients to the importance of the bedside discussions throughout the hospital stay.

PFE 3: Dedicated Person of Functional Area	Ensure PFE efforts are built into the management of hospital operations and given the attention and resources needed to be successful and sustained over time.	• There is a named hospital employee who is responsible for PFE efforts. • Appropriate hospital staff members and clinicians can identify the person above. AND/OR • There is a functional area responsible for PFE. • Appropriate hospital staff members and clinicians can name the functional area and identify individuals who work in there.	Met	Lorna Tirman fills this role. You can reach her with the following information: Lorna Tirman 10121 Pine Ave PO Box 759 Truckee, CA 96161 ltirman@tfhd.com (530) 582-6567
PFE 4: Patient Family Engagement (PFE)/ Patient Family Advisory (PFA) Committee (PFEC/PFAC)	Ensure that a hospital has a formal relationship with patient and family advisors (PFAs) from the local community who provide input and guidance from the patient perspective on hospital operations, policies, procedures, and quality improvement efforts	• Patient and/or family representatives from the community have been formally named as members of a PFAC or other hospital committee. (A minimum of one active PFA) • Meetings of the PFAC or other committees with patient and family representatives have been scheduled and conducted.	Met	PFAC regularly meets to engage issues important to our patients and families.
PFE 5: Governing Board	Ensure that at least one Board member with full voting rights and privileges provides the patient and family perspective on all matters before the Board.	• Hospital has at least one position on the Board designated for a patient or family member who is appointed to represent that perspective. • If a specific board representative is not possible, an alternative exists to work with patients and families	Met	Our PFAC Member representing us is Pati. You can contact her using the information below: Pati Johnson PO Box 10015 Truckee, CA 96162 (530) 587-7134

		when making governance decisions.		Paticialjohnson@hotmail.com

Hospital Acquired Infections

At both Tahoe Forest Hospital and Incline Village Community Hospital, hospital-acquired infections (HAI) are rare because of our rigorous prevention and control program. All caregivers and support staff are trained in infection prevention, early identification, and various control practices. We also enable patients and families to take part in infection prevention and identification through patient-centered education and communication. Our Environmental Services (EVS) staff go through frequent training on proper cleaning techniques with hospital-recognized products. Additionally, every patient or visitor can rest assured because our infection control and prevention standards are evidence-based and endorsed by the Centers for Disease Control and Prevention (CDC), the Association for Professionals in Infection Control (APIC), and local and state health agencies. Together, these efforts contribute to desirable patient outcomes. We spend time and effort on these practices because infection prevention is a key factor to help our patients recover quickly and stay healthy.

Specific HAI prevention practices within our health system includes:

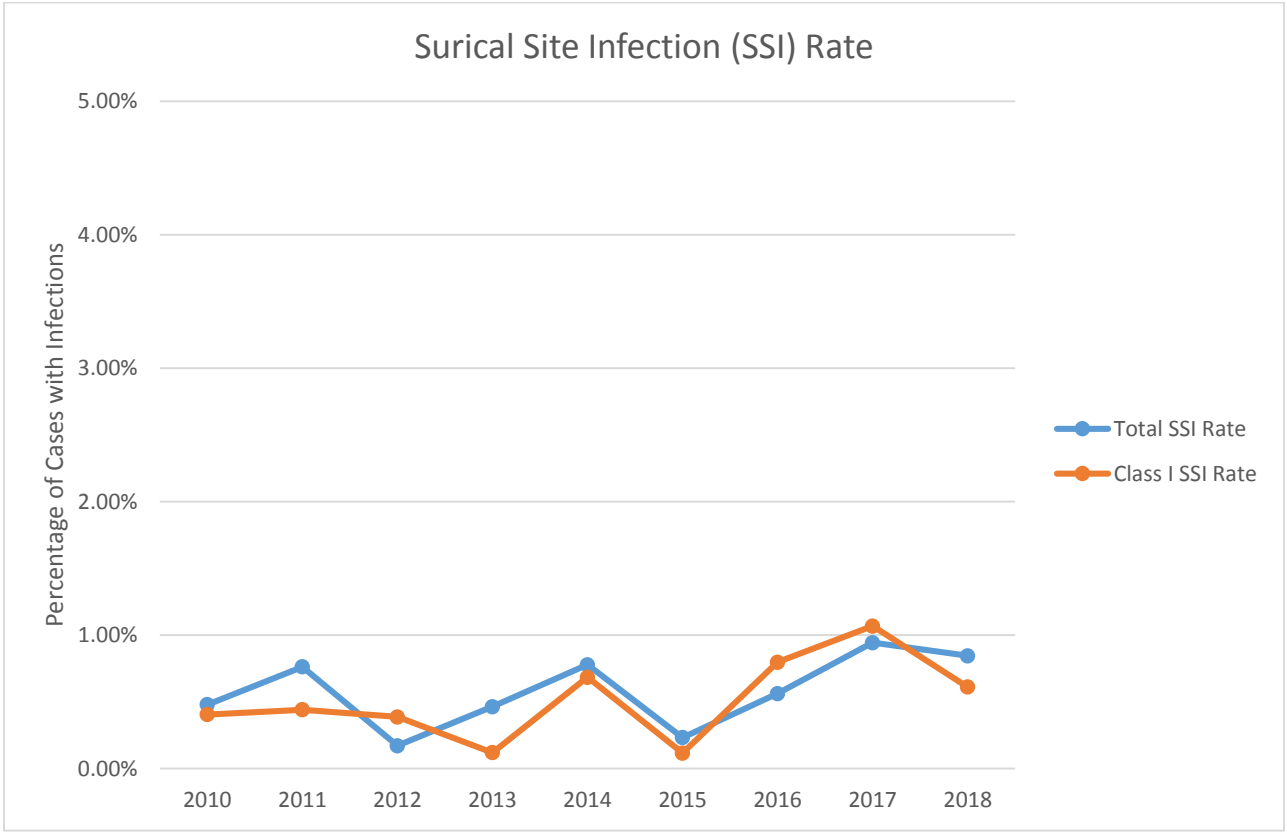
- Ongoing personal hygiene education for all of our healthcare providers, including an aggressive seasonal flu prevention program
- Hospital visitor education that encourages hand hygiene upon entering and exiting a patient room, and not visiting if sick
- A focus on safe work practices: hand hygiene, cleaning and disinfection, safe injection practices, and use of face protection, gloves, and gowns when needed
- Patient education and infection prevention tools prior to, and upon admission, plus follow-up after discharge
- Giving the recommended antibiotics at the right time before surgery
- Stopping antibiotics within the right time after surgery
- Maintaining patient's blood sugar and temperature
- Removing catheters used to drain the bladder in a timely manner after surgery.

We follow the Centers for Disease Control (CDC) guidelines to track the incidence of HAI and report the results regularly. Within our reporting structure, we pay close attention to Clostridium difficile and surgical infections in all four classes of surgery (I, II, III, and IV). Definitions of the surgical classes are provided below:

> *Class I* surgeries are what healthcare workers call "clean"; having a wound that is classified this way means that there is no inflammation and no entry into the respiratory, alimentary, genital or urinary tracts.
>
> *Class II* surgeries are what healthcare workers call "clean-contaminated"; having a surgery classified this way means that the surgeon entered the respiratory, alimentary, genital or urinary tract under controlled conditions and expects no unusual cross contamination.

Class III surgeries are what healthcare workers call “contaminated” surgeries; having a surgery classified this way means that fresh, accidental wounds took place and that the surgeon had at least one major break from sterile technique or that there was spillage of GI contents.

Class IV surgeries are what healthcare workers call “dirty” surgeries; this means that the surgery involves traumatic wounds with dead tissue, foreign bodies, or fecal contamination.



Data source is TFH internal surgical data from 01/01/2010 – 11/30/2018. In this situation, lower values demonstrate better performance.

We also reduce the risk of cardiac problems associated with surgery by:

- Making sure that certain prescription drugs are continued before, during, and just after the surgery. This includes drugs used to control heart rhythms and blood pressure.
- Giving drugs that prevent blood clots, and using other methods such as special stockings to increase circulation in the legs.

- Patients who are admitted to the hospital for treatment of medical problems sometimes get other serious injuries, complications, conditions, and may even die. Some patients may experience problems soon after they are discharged and need to be admitted to the hospital again. These events can often be prevented if hospitals follow best practices for treating patients.

To learn more about how Tahoe Forest Hospital District measures up, click here.

If you have questions about HAI, feel free to reach out and talk with us!

Svetlana Schopp, RN, MSN, CNL, CNOR
Infection Preventionist
sschopp@tfhd.com
(530) 582-8231

Wellness in our Community

The Wellness Neighborhood of Tahoe Forest Health System (TFHS) presents the 2018-2021 Community Health Improvement Plan (CHIP) for the Truckee/North Tahoe region. This CHIP addresses the priority health needs identified in the 2017 and previous Community Health Needs Assessments (CHNAs) from 2011 and 2014, and the Health System strategy for building and supporting a healthy community.

This document presents our three year goals, objectives, and strategies to achieve the identified improvements in health status for our community. Strategies build upon current programs and services as well as introduce new areas for interventions.

To learn more about the programs, please go here.

Cancer Treatment at Tahoe Forest Hospital

Our state-of-the-art Cancer Center is constantly pushing the boundaries of best practice further and further. They do this by regularly engaging in quality research studies and projects that directly relate to our rural patient population with cancer. Some examples of current projects include:

- A quality study to assess head and neck cancer patients to ensure dental needs have been addressed prior to initiation of treatment plan.
- A quality study to assess how often there are delays between the time of breast cancer diagnosis and definitive surgery to determine the factors that may contribute to this delay.
- A quality improvement project to address the 2018 Colon Cancer study which identified Colon Cancer being diagnosed at a later stage than we would expect.
- A quality improvement project to address genetic counseling and/or testing with the following components:
  - Standardized documentation of pre-test counseling and consent

- Streamlined testing process for patients meeting NCCN criteria for highly penetrant genes
- Streamlined referral to genetic counseling for patients with family history of cancer but not meeting criteria for highly penetrant gene testing.

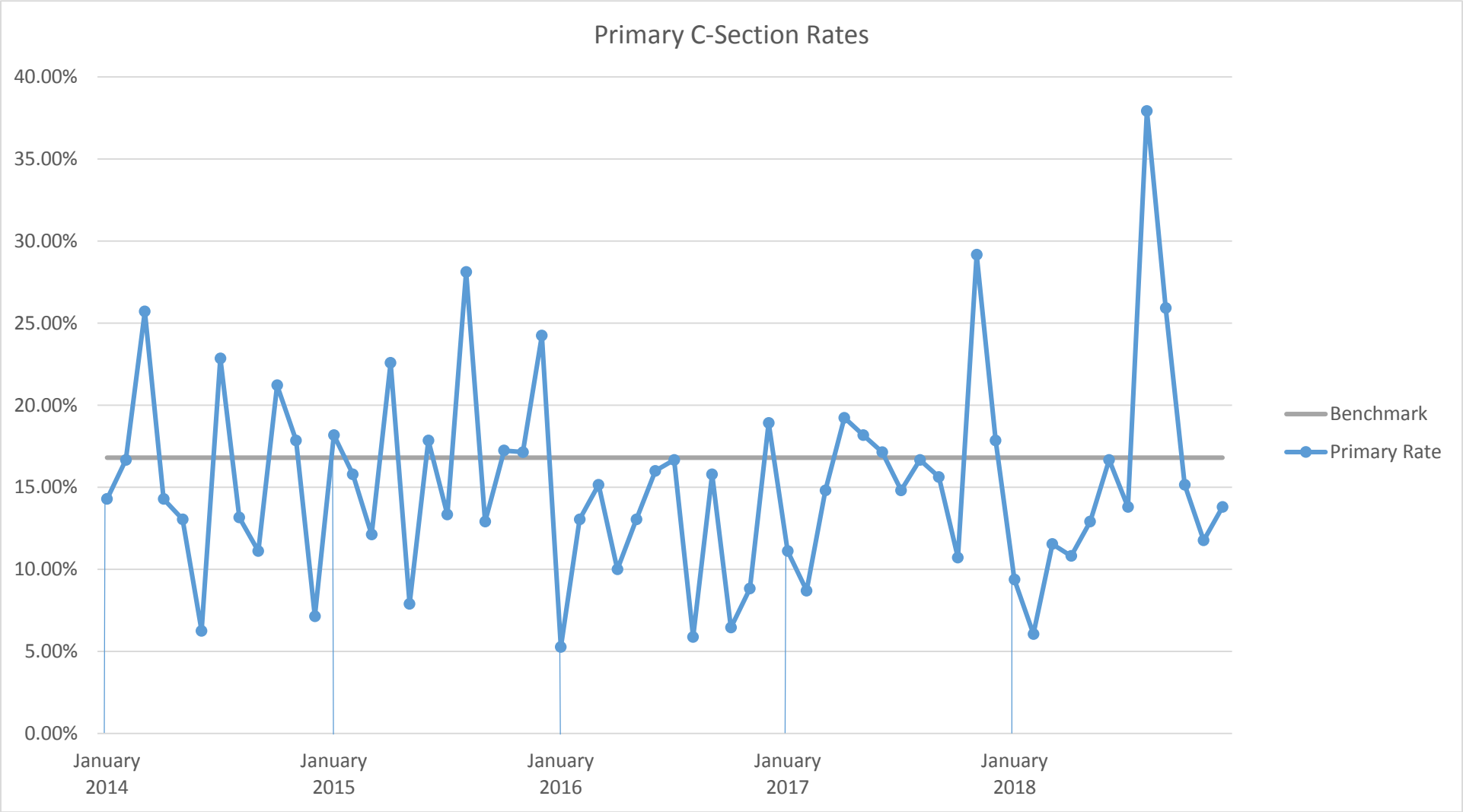
For more information on our Cancer Center, please go here.

Lower Than Expected Caesarean Section Rates

A Caesarean section (C-section) is a type of surgery used to deliver a baby as an alternative to a vaginal delivery. During a C-section, anesthesia is administered so the patient will not feel pain. The doctor makes an incision in the mother's belly and removes the baby from her uterus. About one in three babies in the United States is born through cesarean delivery

While some women voluntarily choose to deliver their baby by C-Section, the most common reasons women have a cesarean delivery before going into labor include:

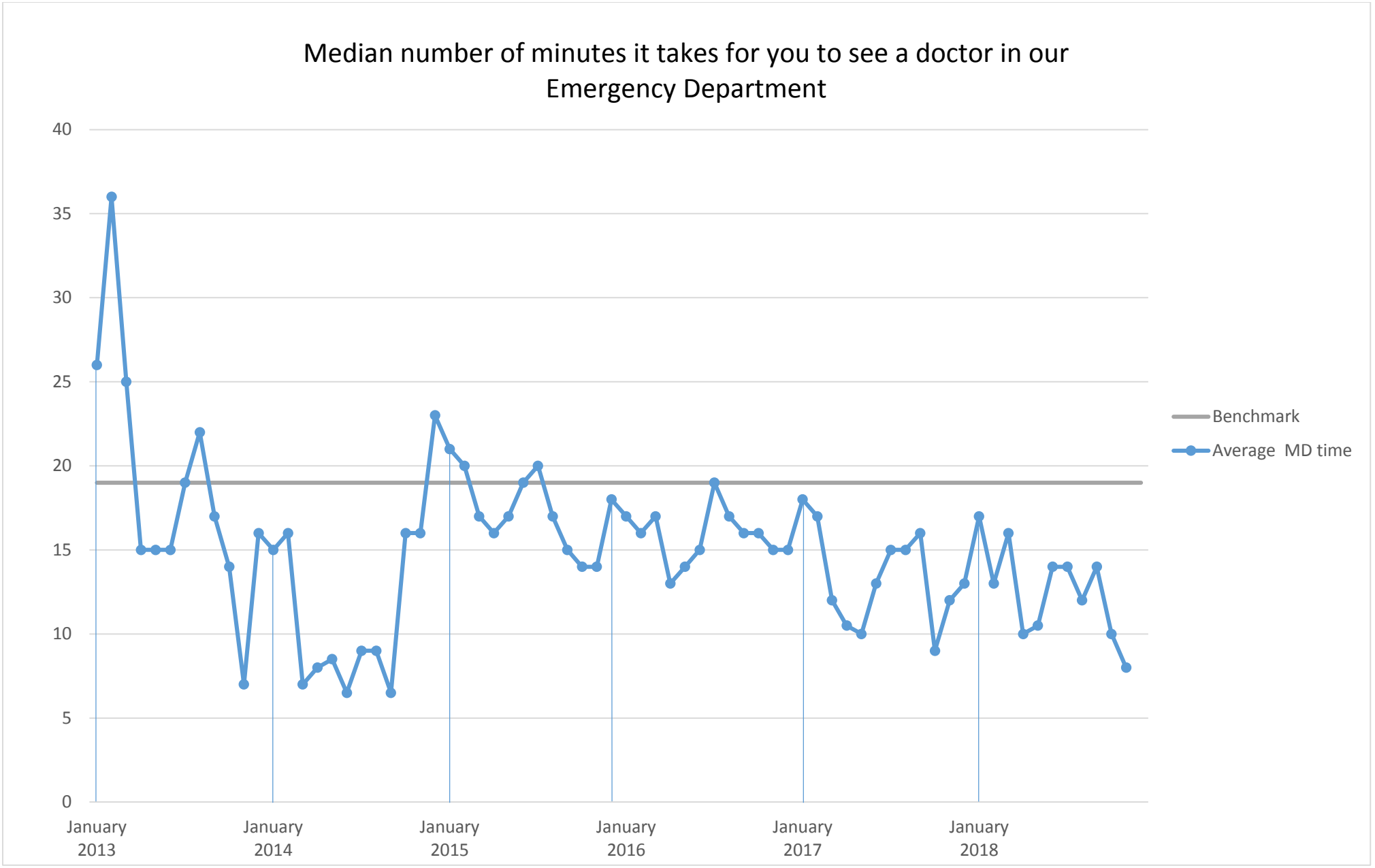
- The mother had a previous C-Section
- The baby is breech (head is not coming out first)
- The baby needs to be delivered many weeks before the due date
- The baby is very large
- The mother has an infection, such as herpes or human immunodeficiency virus (HIV), that can be transmitted to the baby during a vaginal birth
- The mother is carrying two or more babies
- The mother has a condition called "placenta previa," in which the placenta blocks the baby's way to the vagina and the baby cannot get out on its own



Data source is internal C-Section data from 01/01/2014 – 12/31/2018. The Benchmark of 16.80% is provided from the California Maternal Data Center and represents the cut-off for the top 25% of California Hospitals. In this situation, lower values demonstrate better performance.

Emergency Department Waiting Time

On average, the Tahoe Forest Hospital Emergency Department treats approximately 15,000 patients annually and is committed to providing a medical exam of patients as quickly as possible upon arrival. Our staff has maintained an average time from arrival to being seen by a physician to 17 minutes for all our patients in the last 6 years – well below the national average of 22 minutes, respectively.



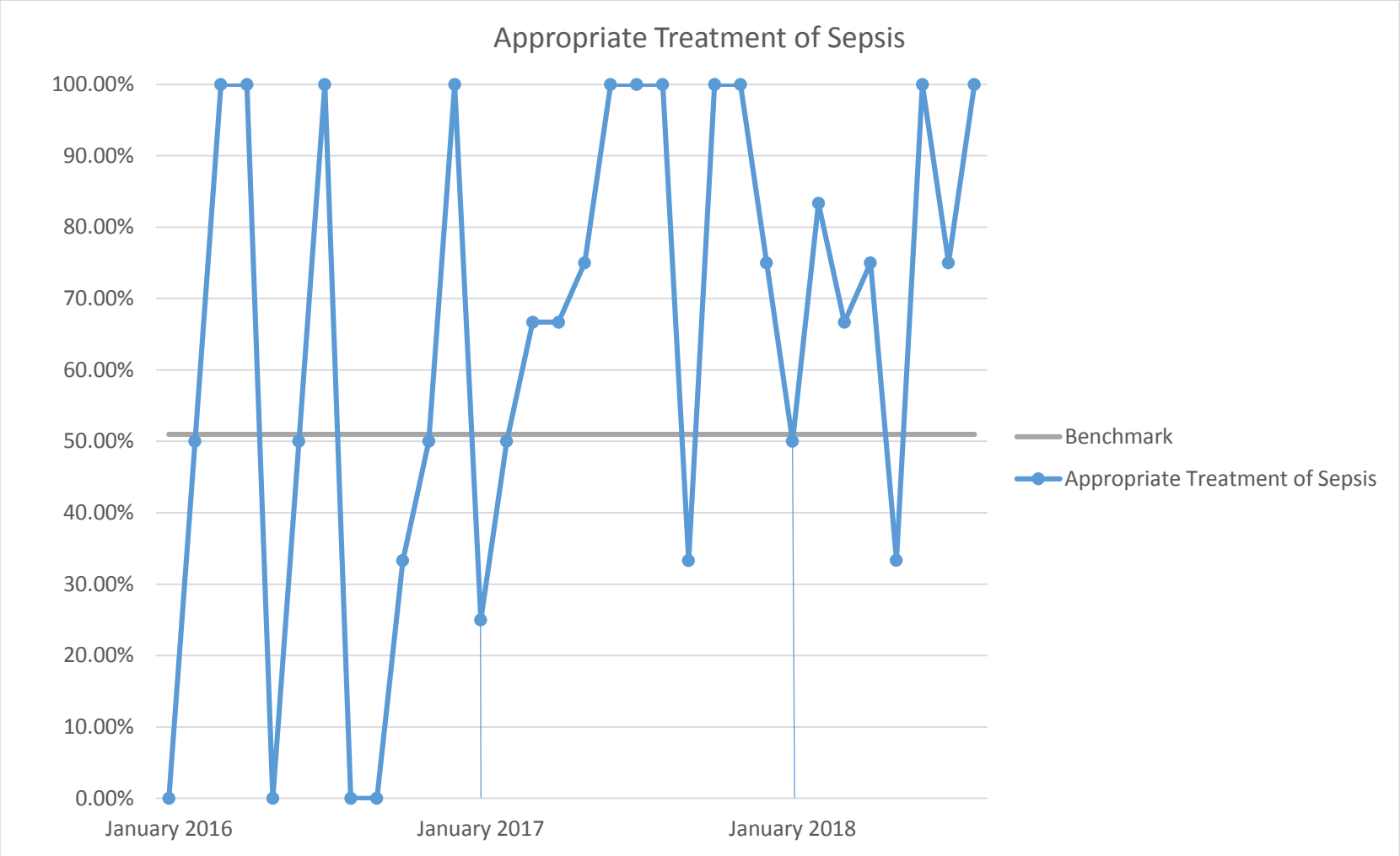
Data source is Quantros Required Reporting Manager from January 2013 through November 2018. Benchmark data of 19 minutes is the Low Volume National Benchmark from the January 2018 Hospital Compare Preview Report. In this context, lower values demonstrate better performance.

Sepsis Care

Sepsis is your body's life-threatening response to an infection due to organ failure, and is the leading cause of death in patients with infection around the world (Source: Infection Prevention and Control at a Glance, Wiley 2017). It is estimated that 1.6 million people are diagnosed with sepsis each year in the US alone, and approximately 258,000 of these people will die of sepsis; this makes sepsis the leading cause of death in US hospitals (Source: sepsis.org).

While any infection can eventually lead to sepsis, this dangerous progression of an infection is usually easy to treat if it is detected early, and at Tahoe Forest Hospital District, that is exactly what we strive to do. Our staff has been trained to identify the risk factors for sepsis and how to treat once identified.

You can read more about sepsis here.

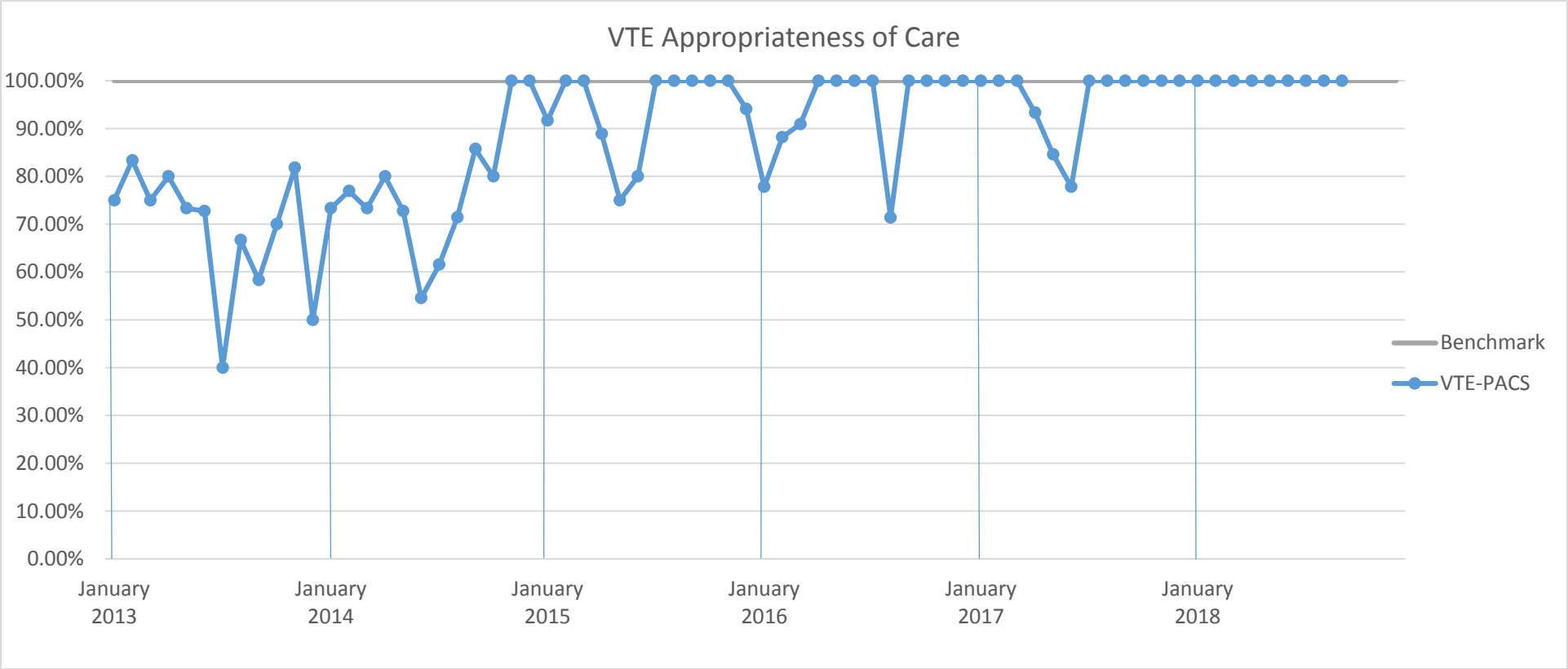


Data source is Quantros Required Reporting Manager from 01/01/2016 – 08/31/2018. Sepsis is a life threatening condition that causes your body to injure its own tissue and organs as you fight an infection. In this situation, higher values demonstrate better performance.

Venous Thromboembolism Care

Venous thromboembolisms (VTE) are blockages of the arteries or veins. This includes deep vein thrombosis or DVT (blockages in the legs) and pulmonary embolisms or PE (blockages in the pulmonary artery or its branches). Typical symptoms of DVT include leg pain, tenderness and warmth of the erythema, while typical symptoms of PE include chest pain and shortness of breath.

At Tahoe Forest Hospital District, we strive to prevent VTEs by following a strict set of rules formed out of nationally-recognized best practices, and it shows! Our regimen of appropriate VTE care includes active VTE prophylaxis post-surgery, appropriate use of anticoagulation medications, dietary advice, follow-up monitoring and adverse drug reaction education among other things.



Data source is Quantros Required Reporting Manager from January 2013 through September 2018. Benchmark is set at 100.00% as all sub-measures have a benchmark at 99.90%. In this situation, higher values demonstrate better performance.

You can read more about VTE here.

Culture of Safety

Tahoe Forest Hospital District is a high reliability organization, which means that we are focused on avoiding patient harm. High reliability organizations are committed to safety at all levels, from frontline healthcare providers to managers and executives. In our organization, we believe you have the right to safe and effective care. This means we are constantly thinking about ways to improve your experience and care. Our culture of safety includes these key features:

- We accept that working and practicing in healthcare is high-risk,
- We are determined to achieve good outcomes 100% of the time,
- We offer a blame-free workplace where people can report errors without fear of punishment,
- We encourage teamwork to solve patient safety problems,
- We are committed to addressing safety concerns with staff, time, supplies, and money.

We partner with the BETA Healthcare Group to continuously improve our culture of safety in these key areas.

If you have any questions about our culture of safety initiatives, reach out!

Dawn Colvin, MPT
Patient Safety Officer
dcolvin@tfhd.com
(530) 582 - 6423

Daily Safety Huddles

Our staff values safety for you, your family, our employees, and our community. This is an important focus for everyone.

In our daily morning huddles, leaders throughout the hospital discuss safety, quality, and service events that happened the previous day and highlight any concerns for the current day. This brief daily meeting happens so that the team is aware of any areas of concern and keeps patient safety in the forefront of their work.

Barcode Scanners for Medications

Medication safety is a priority for our staff because it is important to our patients, families, and communities that we serve. This is why we use barcode scanners anytime we administer a medication. This process is a check and balance to ensure the correct medication and dosage is given to the correct patient at the correct time.

Safe Prescribing

We know that opioid use and abuse is a national epidemic, which is why our hospitals and physicians work with the States of California and Nevada to ensure patients get an appropriate prescription for an appropriate length of time. California utilizes the using the Controlled Substance Utilization Review and Evaluation System 2.0 (CURES 2.0) database, while Nevada uses the Prescription Monitoring Program (PMP) database.

Both of these databases track Schedule II, III and IV controlled substance prescriptions that are dispensed, and are used by hospitals, pharmacies, regulatory oversight agencies and law enforcement to monitor the appropriate usage and prescribing of controlled substances to patients. This is a direct benefit to patients because it ensures they are not over-prescribed medications that can contribute to unintended harm.

If you have questions about this initiative, reach out to us!

Nicholas T. Vu, Pharm.D.
Director of Pharmacy
nvu@tfhd.com
(530) 582-6465

Information Presented to the Medical Staff and Board of Directors

Our Medical Staff and Board of Directors set demanding expectations for the care we provide. As such, we benchmark ourselves against the best hospitals in the state and in the nation. Our focus and commitment to quality outcomes has made us a leader in the region and we are frequently asked to share this information publicly and with other hospitals. We provide you with the same information that we provide our Board of Directors and Medical Staff. You can access our data here.

Transparency and Disclosures

It is Tahoe Forest Hospital District's policy to support the rights of patients to be active participants in decisions about their healthcare. As such, we provide the necessary information to make an informed decision about your treatment and care plan. In addition, a patient and/or their family/designee will be informed about any outcome of their treatment, including any unexpected errors in care.

While we take every possible precaution during your treatment, unexpected things do happen. In those situations, it is our policy to promptly communicate an unanticipated outcome to the patient and/or the patient's family or designee. In that communication, we guarantee:

1. A clear, factual explanation of the known error or unanticipated outcome and the known impact of this on the patient's treatment and prognosis.
2. A clear explanation of the steps taken to decrease the harm.

3. A clear statement indicating that a review will take place to learn as much as possible about the unanticipated outcome and/or error in order to prevent similar events in the future.
4. Information regarding resources available to support and comfort the patient and/or family, including, offering Patient Advocate assistance.
5. Expressions of empathy and sympathy for the patient's inconvenience, distress, or discomfort.
6. An apology, as appropriate, for the circumstances.

Websites for Interested Patients

Every patient has a right to see how we compare to other hospitals. The following websites contain different information, initiatives, ratings, rankings, or benchmark information related to the services we provide.

Data and Definitions

- Medicare Data Sets - All Hospitals, Nationwide
- Person and Family Engagement Metrics
- HSAG HIIN Compendium of Measures
- California Opioid Overdose Surveillance
- The Joint Commission (TJC)
- National Healthcare Safety Network (NHSN)

Sites with Comparisons

- Home Health Compare – Tahoe Forest Hospital
- Hospice Compare – Tahoe Forest Hospital
- Cal Hospital Compare – Tahoe Forest Hospital
- Hospital Compare - Tahoe Forest Hospital
- Hospital Compare – Incline Village Community Hospital
- Nursing Home Compare – Tahoe Forest Hospital

Informational Sites

- Health Services Advisory Group (HSAG)
- Agency for Healthcare Research and Quality (AHRQ)
- Quality Net (QNet)
- California Department of Public Health (CDPH)
- Controlled Substance Utilization Review and Evaluation System (CURES)
- Healthcare Facilities Accreditation Program (HFAP)

- Becker’s Hospital Review
- Centers for Medicare & Medicaid Services

Please reach out if you have any questions about this information or have additional suggestions.

Joshua Fetbrandt, MS, CPHQ
Quality Analyst
jfetbrandt@tfhd.com
(530) 582-3272

Have a question about our Quality Program?

We'd love to hear from you! Providing easily accessible information to our patients and families is just one way of making decisions about your health care. We encourage you to contact our Quality and Regulations Department with questions you may have about the information on these pages.

Janet Van Gelder, RN, DNP, CPHQ, NEA-BC
Director of Quality and Regulations
jvangelder@tfhd.com
(530) 582-6629

Star Rating by Centers for Medicare and Medicaid Services for Patient Satisfaction
The Centers for Medicare and Medicaid (CMS) award star ratings to hospitals based on their patient satisfaction scores, and possible ratings are from on the five stars, with five stars being the best. These scores are meant to help consumers compare hospital quality measurements. Many of the nation's best hospitals receive average (three-star) ratings, but Tahoe Forest Hospital is one of the few hospitals that consistently scores at least four stars.

Named one of America's Top 100 Critical Access Hospitals in 2012
Tahoe Forest Hospital was named one of the Top 100 hospitals in the country by the National Rural Health Association, one of only four in the state of California. Read more about it here.

UC Davis Rural Center of Excellence
Being designated a UC Davis Rural Center of Excellence recognizes a commitment to offering quality care in our community. Bridging gaps in health care services, linking to specialists, and giving physicians access to the latest medical education and training is important. Read more about it here.

Proud Affiliate – UC Davis Comprehensive Cancer Center
We are a proud affiliate of the UC Davis Comprehensive Cancer Center, a network that unites five hospital-based cancer centers dedicated to providing exceptional cancer treatment in rural settings. Read more about it here.

UC Davis Rural PRIME Medical Education Program
Tahoe Forest Hospital has partnered with UC Davis School of Medicine to offer an innovative training program for third and fifth year medical students with local primary care physicians. Read more about the Rural Partners in Medical Education Program here.

CAPE Gold Recipient for Performance Excellence
Tahoe Forest is a recognized for world-class service and performance excellence by the California Awards for Performance Excellence (CAPE). For more information, click here.

American Society of Clinical Oncology (ASCO) Quality Oncology Practice Initiative Certification
Electronic health records are now part of a growing CancerLinQ® database to help physicians uncover patterns and trends and receive real-time quality feedback. Find out more here.

American Society of Radiation Oncology (ASTRO) Accreditation Program for Excellence
The Gene Upshaw Memorial Tahoe Forest Cancer Center achieves four-year accreditation for radiation oncology services. Read more here.

Addario Lung Foundation Center of Excellence
The ALCF Centers of Excellence award recognizes community hospitals for their individualized care and treatment of lung cancer patients. Read more here.

Five Star Service Rated Children's Center
Tahoe Forest Hospital's Children's Center is rated 5 stars by the Nevada County Child Care Coordinating Council, read more here.

America's Best Hospitals for Obstetrics
The Joseph Family Center for Women and Newborn Care has been given the Women's Choice Award for America's Best Hospitals for Obstetrics. Read more here.

UC Davis Rural Center of Excellence
Being designated a UC Davis Rural Center of Excellence recognizes a commitment to offering quality care in our community. Bridging gaps in health care services, linking to specialists, and giving physicians access to the latest medical education and training is important. Read more about it here.

Commission on Cancer Accreditation with Commendation
The Commission on Cancer of the American College of Surgeons has granted three-year accreditation to the cancer program at the Gene Upshaw Memorial Tahoe Forest Cancer Center. Read more here.

American Society of Radiation Oncology (ASTRO) Accreditation Program for Excellence
The Gene Upshaw Memorial Tahoe Forest Cancer Center achieves four-year accreditation for radiation oncology services. Read more here.

Baby Friendly
Tahoe Forest Hospital is certified "Baby Friendly." For more information about our commitment to the highest quality of care, support and education for infants, click here.

Excellence in Innovation and Quality
The National Rural Resource Center awarded Tahoe Forest Hospital with the Excellence in Innovation and Quality award. Read more here.

CALNOC Performance Excellence Award
Tahoe Forest Hospital was recently recognized for excellent performance in the reduction of hospital acquired pressure ulcers, injuries from falls and infections. Read more here.

Everything from here on are Josh's notes for future updates.

What the Committee Wants to See:

1. How safe is this hospital, mortality, lowest here and there in
2. Less performing at the bottom
3. Click to open tab; remember the focus is good information, less on the "dissertation" aspect.
4. Graphical information as opposed to words?

Future Ideas:

1. Interactive Data Sets: Good ideas? Tableau (do we have it)?
2. Disparity data (age, gender, type of care, severity, etc.)
3. Infection rate
4. Risk adjusting patients and procedures
5. Knowing basic demographic information, volumes in services lines, throughput relative to community size a day. Disparity data
6. Look at physician rating? Maybe moving forward. Look into. Want to know about the physicians personally. Look at renown, Stanford. Insurance they take?
7. Outpatient schedules, services, etc. criteria for admission, etc.
8. What to ask your doctor link
9. PFAC picture
10. PFAC bio's – community member bios and listing a staff and department
11. **Preparing for your Admission or Surgery -** As you prepare
12. **Cancer Center Initiatives** *To fill in with Kelley. Waiting for meeting.*
13. **FAQs** *To fill in with PFAC.*

Hi Joshua

Good to hear from you.

I suppose as a parent of teenagers, the areas I thought might be of interest are:-

I would like tables charts or infographics illustrating:-

- Age bands of young people, ie, children, teens, young people (not sure if there is any official age grouping in California
- Common reasons they were admitted, the proportion of total admissions that belong to this age band
- Recovery times / How quickly they were able to go home

- Re-admitted cases
- How satisfied were the patients/parents with their treatment?
- What was the hospital good /bad at.

For me personally, race isn't as interesting a factor, as injuries, age groups, recovery times are.

Hope this helps

Parminder

Ideas that were nixed:

1. Mention of Lean/6 Sigma/Continuous Improvement?
2. HIIN Measures 1 – 15: *Medicare Data only. https://hiin.hshapps.com/Account/Login?ReturnUrl=%2F*
3. Good Catches
4. BOD and/or Med Staff Dashboards

EXECUTIVE SUMMARY: MEETING THE DEMAND FOR HEALTH

FINAL REPORT OF THE CALIFORNIA FUTURE HEALTH WORKFORCE COMMISSION

Introduction: A Looming Workforce Crisis

California's health system is facing a crisis, with rising costs and millions of Californians struggling to access the care they need. This growing challenge has many causes and will require bold action by the new governor, legislators, and a broad spectrum of stakeholders in the public and private sectors. At the core of this challenge is the simple fact that California does not have enough of the right types of health workers in the right places to meet the needs of its growing, aging, and increasingly diverse population.

The California Future Health Workforce Commission has spent nearly two years focused on meeting this challenge, issuing a new report with recommendations for closing California's growing workforce gaps by 2030.

The Problem: Workforce Shortages, Provider Mismatches

In many parts of the state, this crisis is already at hand: Seven million Californians, the majority of them Latino, African American, and Native American, already live in Health Professional Shortage Areas — a federal designation for counties experiencing shortfalls of primary care, dental care, or mental health care providers. These shortages are most severe in some of California's largest and fastest-growing regions, including the Inland Empire, Los Angeles, and San Joaquin Valley, and in most rural areas.

As a generation of baby boomers retires — including a large percentage of the health workforce — and as living costs rise and the state's production of health workers continues to lag growing demands, millions more Californians will find it difficult to access quality, affordable care. This looming crisis will be most acute in primary care, behavioral health, and among workers who care for older adults. In just 10 years, for example, California is projected to face a shortfall of more than 4,100 primary care clinicians and 600,000 home care workers, and will have only two-thirds of the psychiatrists it needs.

About the California Future Health Workforce Commission

The Commission was co-chaired by Janet Napolitano, president of the University of California (UC), which operates the largest health sciences education and training system in the nation and is a major health provider, and Lloyd Dean, president and CEO of Dignity Health, one of the state's largest health systems and health employers. The 24 commissioners included prominent health, policy, workforce development, and education leaders in the state.

To adequately fill these gaps, the state must also overcome the growing mismatch between its existing workforce and the state's increasingly diverse population. People of color will make up the majority of Californians by 2030, but they remain severely underrepresented in the health workforce. While Latinos are now nearly 40% of the state's population, for example, they compose only 7% of physicians. More than seven million Californians have limited English proficiency and would benefit from multilingual providers — yet few are available.

The Solution: A Comprehensive Plan to Build the Workforce That California Needs

The California Future Health Workforce Commission was created in 2017 by a group of the state's leading health philanthropies to address this looming crisis — and to create a comprehensive action plan for building the health workforce California will need by 2030.

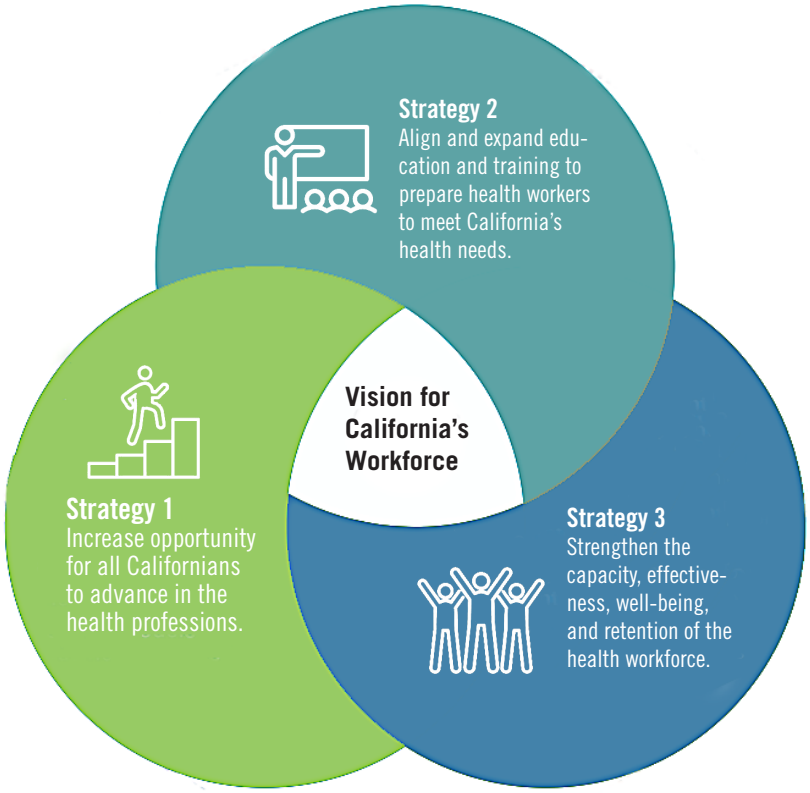
The Commission's final report includes a set of 27 detailed recommendations within three key strategies that will be necessary for: (1) increasing opportunities for all Californians to advance in the health professions, (2) aligning and expanding education and training, and (3) strengthening the capacity, retention, and

effectiveness of health workers. Throughout its deliberations, the Commission has focused on the need to increase the diversity of the state's health workforce, enable the workforce to better address health disparities, and incorporate new and emerging technologies.

While advancing all 27 recommendations over the next decade will be important, the Commission has highlighted 10 priority actions that its members have agreed would be among the most urgent and most impactful first step toward building the health workforce that California needs. (See next page.)

To make these proposals a reality, the Commission also recommended establishing statewide infrastructure, starting in 2019, to implement the recommendations in partnership with stakeholders, to monitor progress, and to make adjustments as needs and resources change. This statewide effort will need to be paired with strong regional partnerships to advance local workforce and education solutions.

The Values and Strategies of the California Future Health Workforce Commission



By 2030, California's health workforce will reflect the diversity of the state and have the capacity and competencies to:

- Improve health, equity, and well-being in all communities.
- Provide accessible, affordable, high-quality services at the right time, at the right level, and in the right places.
- Transform health care delivery to address social needs and improve health outcomes across the life course.

Priorities for Action

California leaders, stakeholders, and partners in health professions education and health care delivery must embrace bold steps to create and sustain the health workforce that communities need now and will need in the future. The Commission's bold and far-reaching recommendations reflect the new directions and significant commitment required by multiple stakeholders to motivate, prepare, and provide opportunities for Californians from all backgrounds and communities to excel in the health professions, to train enough new workers to meet statewide and regional needs, and to support current workers by strengthening their capabilities and preventing burnout.

The Commission's 10 priorities for immediate action and implementation are:

1. **Expand and scale pipeline programs to recruit and prepare students from underrepresented and low-income backgrounds for health careers** with mentorship, academic, career, and psychosocial support. Under these health pipeline programs, as many as 5,700 low-income and underrepresented minority professionals will be able to join the California health care workforce during a 10-year period at a cost of just $11,000 per person. (Recommendation 1.1)
2. **Recruit and support college students, including community college students, from underrepresented regions and backgrounds to pursue health careers,** and form associated partnerships that provide academic, advising, and health career development support. College students from low-income and first-generation backgrounds will be targeted for inclusion in this priority, which has the potential to add at least 25,500 new California health care workers over 10 years. (Recommendation 1.2)
3. **Support scholarships for qualified students who pursue priority health professions and serve in underserved communities** under a new Emerging California Health Leaders Scholarship Program. Approximately 3,810 students (1,707 physicians, 696 nurse practitioners, 152 physician assistants, 325 public health professionals, and 930 social workers) would be supported over the next 10 years, making the path to health education and service in underserved communities a reality for many more Californians. (Recommendation 1.3)
4. **Sustain and expand the Programs in Medical Education (PRIME) program across UC campuses** to train highly motivated, socially conscious graduates who will become licensed physicians practicing in underserved communities. Under this priority, the goal is to support PRIME's current student enrollment of 354 students and increase enrollment by 40 students a year. (Recommendation 2.1)
5. **Expand the number of primary care physician and psychiatry residency positions,** yielding an increase of 1,872 primary care physicians and 2,202 psychiatrists by 2030. In conjunction with priorities 7 (maximize role of nurse practitioners) and 9 (psychiatric nurse practitioners), this recommendation would eliminate California's projected shortage of primary care physicians and psychiatrists. (Recommendation 2.2)
6. **Recruit and train students from rural areas and other underresourced communities to practice in community health centers in their home regions** by providing these medical students with full-tuition scholarships for medical school in exchange for practicing in underserved areas. Once this partnership with 10 California medical schools and several community health centers is fully implemented in 2026, it's anticipated that California would see an increase of 200 to 480 additional medical students annually. (Recommendation 2.3)
7. **Maximize the role of nurse practitioners as part of the care team to help fill gaps in primary care,** helping to increase the number of nurse practitioners to 44,000 by 2028, and providing them with greater practice authority, with particular emphasis in rural and urban underserved communities. (Recommendation 3.1)
8. **Establish and scale a universal home care worker family of jobs with career ladders and associated training,** helping to meet the need for an estimated 600,000 home care workers by 2030, and potentially reducing spending on unnecessary emergency department visits and hospitalizations by more than $2.7 billion over 10 years due to enhanced training and care. (Recommendation 3.2)

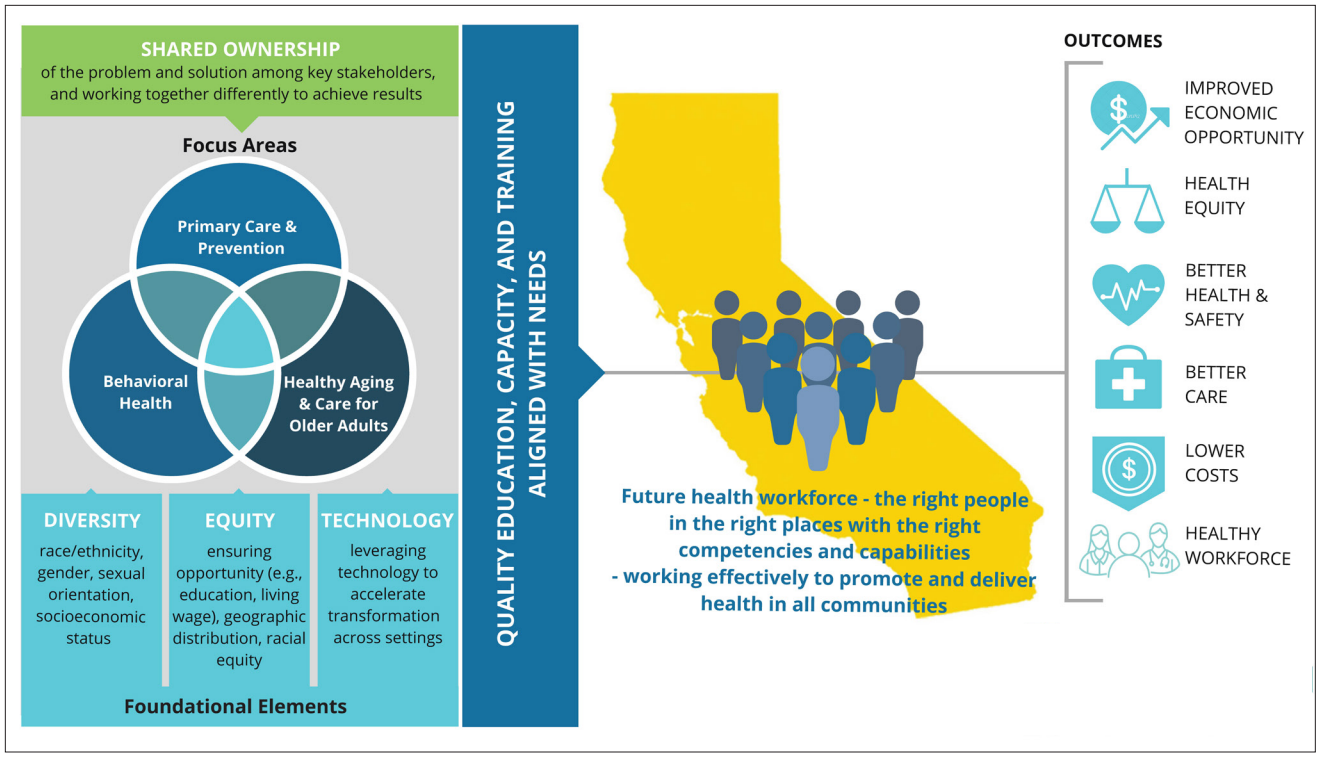
9. **Develop a psychiatric nurse practitioner program that recruits from and trains providers to serve in underserved rural and urban communities** to help address access gaps in behavioral health by treating over 350,000 patients over five years. (Recommendation 3.3)
10. **Scale the engagement of community health workers, *promotores*, and peer providers through certification, training, and reimbursement,** broadening access to prevention and social support services in communities across the state. Community health workers and *promotores* (CHW/Ps) and peer providers can help meet increasing demand for team-based integrated primary and behavioral health care, drawing on lived experience to support better outcomes for all and to promote recovery and self-sufficiency for people with mental illness and substance use disorder. (Recommendation 3.4)

Together, the Commission's prioritized recommendations will:

- Grow, support, and sustain California's health workforce pipeline by reaching over 60,000 students and cultivating careers in the health professions.
- Increase the number of health workers by over 47,000.
- Improve diversity in the health professions, producing approximately 30,000 workers from underrepresented communities.
- Increase the supply of health professionals who come from and train in rural and other underserved communities.
- Train over 14,500 providers (physicians, nurse practitioners, and physician assistants), including over 3,000 underrepresented minority providers.
- Eliminate the shortage of primary care providers and nearly eliminate the shortage of psychiatrists.
- Train more frontline health workers who provide care where people live.

Implementation will require a $3 billion investment over a 10-year period: For perspective, that is less than 1% of what Californians are projected to spend across the health care system in 2019 alone.

A 2030 Workforce Plan: Foundational Elements, Focus Areas — and Outcomes



Additional Recommendations

In addition to its 10 priorities for action, the Commission has developed 17 other important recommendations to address critical health workforce needs, for a combined estimated cost of $6 billion. Many of these proposals will help retool California's health workforce to strengthen prevention, improve behavioral health care, and address social determinants of health. Together, these recommendations represent a mix of proven models and bold initiatives and will require a mix of short- and long-term investments.

Although the Commission focused on identifying workforce solutions, its final report acknowledges several other factors that will impact the success of building the health workforce that California needs. For example, without adequate Medi-Cal payment rates, an accelerated shift to value-based payment, effective preparation of K–12 students, and the ability for California to address other "essential conditions," even well-intentioned efforts to address the state's health workforce needs may fall short.

Conclusion: California Must Build the Health Workforce It Needs Now

The Commission recognizes that bolstering California's health workforce is an enormous undertaking. Health care represents almost 12.6% of the state's economy, employing 1.4 million skilled workers across dozens of different, highly technical, and closely regulated fields. A robust and diverse health workforce is also increasingly a matter of public health. The growing mismatch between the size and composition of California's current health workforce, the demographic trends underway, and California's limited educational capacity to close growing shortfalls has created a looming health workforce crisis that the state simply cannot afford.

By strengthening the supply, distribution, and diversity of workers in primary care, behavioral health care, care for older adults, and other emerging areas of need, Californians will receive better access to quality care and experience better health outcomes — whether receiving that care in their homes, community clinics, or medical offices. Students and health professionals from underserved regions and low-income backgrounds will have expanded opportunities and better support to pursue rewarding educations and careers. And, ultimately, California will benefit from a healthier population, with more residents receiving the right type of care from trusted health professionals in their communities.

It's time to invest in, support, and build a healthy, diverse, and robust workforce that all Californians need and deserve. The California Future Health Workforce Commission has set forth a path and set of actionable recommendations for achieving that goal.