2020-01-22 Board Quality Committee Meeting

Wednesday, January 22, 2020 at 12:00 p.m.

Tahoe Forest Hospital - Eskridge Conference Room

10121 Pine Avenue, Truckee, CA 96161

Meeting Book - 2020-01-22 Board Quality Committee Meeting

01/22/2020 Quality Committee

AGENDA

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5. APPROVAL OF MINUTES

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6. ITEMS FOR COMMITTEE DISCUSSION AND/OR RECOMMENDATION

6.1. Safety First

6.2. Patient & Family Centered Care

6.2.1. PFAC Summary for Quality Board_ 1_22_2020.pdf Page 8

6.3. Patient Safety

6.3.1. BETA HEART Progress Grid updated 2020-01-08.pdf Page 9

6.4. DRAFT Quality Assessment_ Performance Improvement (QA_PI) Plan, AQPI-05.pdf Page 10

6.5. IHI Framework for Governance Quality White Paper.pdf Page 22

6.6. HFAP Overview 040819.pdf Page 58

6.7. Board Education

6.7.1. AHA Rural-Report-2019.pdf Page 68

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QUALITY COMMITTEE
AGENDA

Wednesday, January 22, 2020 at 12:00 p.m.
Eskridge Conference Room, Tahoe Forest Hospital
10121 Pine Avenue, Truckee, CA

1. CALL TO ORDER

2. ROLL CALL
Mary Brown, Chair; Alyce Wong, RN, Board Member

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

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

5. APPROVAL OF MINUTES OF: 11/14/2019 .... **ATTACHMENT**

6. ITEMS FOR COMMITTEE DISCUSSION AND/OR RECOMMENDATION

6.1. Safety First

6.2. Patient & Family Centered Care

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

6.3. Patient Safety

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

6.4. Quality Assurance/Process Improvement Plan (QA/PI) .... **ATTACHMENT**
Quality Committee will receive a summary report of the QA/PI 2019 Priorities and discuss recommendations for 2020 priorities.

6.5. Governance of Quality Assessment (GQA) Tool .... **ATTACHMENT**
Quality Committee will review the assessment tool and discuss the status of core processes needed to effectively oversee quality as discussed in *Framework for Effective Board Governance of Health System Quality (2018)*.

6.6. Healthcare Facilities Accreditation Program (HFAP) .... **ATTACHMENT**
Quality Committee will receive an overview of the HFAP survey process.

6.7. Board Quality Education

6.7.1. American Hospital Association (AHA) Report on Rural Communities .... **ATTACHMENT**
Committee will discuss the following AHA report: *Rural Report: Challenges Facing Rural Communities and the Roadmap to Ensure Local Access to High-quality, Affordable Care*

(2019).

7. REVIEW FOLLOW UP ITEMS / BOARD MEETING RECOMMENDATIONS

8. NEXT MEETING DATE

The next committee date and time will be confirmed.

9. ADJOURN

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

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

Equal Opportunity Employer. The 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.

QUALITY COMMITTEE
DRAFT MINUTES

Thursday, November 14, 2019 at 9:00 a.m.
Eskridge Conference Room, Tahoe Forest Hospital
10121 Pine Avenue, Truckee, CA

1. CALL TO ORDER
Meeting was called to order at 9:03 a.m.

2. ROLL CALL
Board: Mary Brown, Chair; Alyce Wong, RN, Board Member

Staff in attendance: Harry Weis, Chief Executive Officer; Dr. Shawni Coll, Chief Medical Officer; Janet Van Gelder, Director of Quality; Lorna Tirman, Patient Experience Specialist; Martina Rochefort, Clerk of the Board

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

4. INPUT – AUDIENCE
No public comment was received.

5. APPROVAL OF MINUTES OF: 08/06/2019
Director Wong moved to approve the Board Quality Committee minutes of August 6, 2019, seconded by Director Brown.

6. ITEMS FOR COMMITTEE DISCUSSION AND/OR RECOMMENDATION
6.1. Safety First
Lorna Tirman, Patient Experience Specialist, presented Safety First on handoff communication.

Directors Brown and Wong were able to attend the daily huddle prior to the committee meeting. Both board members spoke to its value.

6.2. Patient & Family Centered Care
6.2.1. Patient & Family Advisory Council (PFAC) Update
Patient Experience Specialist provided an update related to the activities of the Patient and Family Advisory Council (PFAC).

The PFAC is currently made up of 10 members. Some members have shown interest in sitting on different committees.

PFAC is always looking on how to improve processes.

Allie Rohe recently came to provide an update on the customer service financial program.

Karen Baffone, Chief Nursing Officer, joined the meeting at 9:09 a.m.

PFAC will meet next week and receive an update on just culture.

Director Wong inquired about PFAC input on quiet packs for quiet at night scores. Patient Experience Specialist stated the quiet packs have been ordered but not yet received. Patient Experience Specialist will bring a sample to the next committee meeting.

CNO said ICU is where the lowest scores occur for quiet at night usually because of alcohol detox and 5150 patients. Behavioral Health has started to address alcohol from a medication standpoint.

Discussion was held on service recovery cards. Diagnostic Imaging has the highest spend of service recovery card, approximately $2,000 per quarter.

6.3. Patient Safety

6.3.1. BETA HEART Program Progress Report

Quality Committee received a progress report regarding the BETA Healthcare Group Culture of Safety program.

Director of Quality reviewed the BETA progress report.

Dr. Tim McDonald was onsite as part of the training on October 23, 2019. Staff performed mock disclosures. It helped us identify who we want to have on disclosure team.

Director Wong noted some completion dates are coming due in spring and inquired if the District is on track. Director of Quality confirmed the initiatives are on track. Dawn Colvin is the lead on the BETA HEART program.

This is year three for Tahoe Forest to attend the BETA Conference and quality is looking for the next group of attendees to send. CNO noted the last BETA conference was the best conference she had ever attended. Staff appreciates the support of the board.

Director Wong inquired if there a way to get more physicians to attend the BETA conference. CMO stated up and coming leaders are identified to help carry the message for years to come.

6.4. Quality Assurance/Process Improvement Plan (QA/PI)

The Quality Assurance/Process Improvement Plan is annually reviewed by the medical staff and board quality committees.

Director of Quality reviewed each of the priorities and felt the priorities should remain the same for 2020.

Discussion was held on education of medical physician burnout. CMO shared about an informative presentation that was given by Brian Sexton from Duke University.

Director Brown thought it would be nice to maintain a list of speakers for the Hobday Medical Lectureship.

Director Brown inquired if staffing is adequate to make the improvements in the electronic health record.

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Josh Fetbrant, Quality Analyst, received his EPIC certification to help pull quality data out of the system.

CMO added that med staff uses the strategic plan framework so there is alignment with the board's vision.

6.5. Governance of Quality Assessment (GQA) Tool

Quality Committee reviewed the assessment tool and discuss the status of core processes needed to effectively oversee quality as discussed in *Framework for Effective Board Governance of Health System Quality (2018)*.

CEO shared that administration met and scored out the quiz shown on page 28 of the packet. Administration came up with 40 out of 59. Item 2 in category 6 was not applicable to our organization. Director Wong also scored the items and received a similar score. She felt she couldn't score item 4 of category 3. CEO felt we did meet this metric.

Discussion about reporting out average cost per discharge data.

Director Brown asked what can be done with the survey at the board level to inform board members. This appears to be a good tool to use.

CMO suggested looking at lower scoring items to see where we can improve reporting to the board.

The retreat might be best place to review in depth especially with two new board members.

Quality Committee agreed to add the framework chart on page 24 to the QAPI plan.

6.6. Board Quality Education

6.6.1. 2020 Board of Directors Quality Reporting Calendar

Director of Quality reviewed the proposed quality reporting calendar.

The quality tool could also help us identify what reporting should be done to the board.

Committee would like to hear about the expansion of cardiac rehab to the Pritikin program.

7. REVIEW FOLLOW UP ITEMS / BOARD MEETING RECOMMENDATIONS

Director Wong asked for follow up on the organizational wide effort working on myChart.

8. NEXT MEETING DATE

The next Board Quality Committee meeting was confirmed for January 22, 2020 at noon.

9. ADJOURN

Meeting adjourned at 10:30 a.m.

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Patient and Family Advisory Council Summary Report: August 2019 to January 2020

Submitted by: Lorna Tirman, Patient Experience Specialist, PhD, MHA, RN, CXPX

The Tahoe Forest Hospital Advisory Council meets every month; 9 months in the year. We do not meet in July, August or December. There are currently 9 active volunteer community members and 6 TFHD leaders who attend.

The Council agreed in January 2019 that their work will be aligned with the hospital strategic plan to assist leadership in creating the perfect care experience for every patient, every time.

Plan for 2019-2020 is to continue to review patient feedback and comments from patient experience surveys. Meetings are focused on improving processes and behaviors to continue to provide the Perfect Care Experience to our community and visitors. Also giving input to service areas and departments on specific programs or new initiatives to make sure it is community centered. We plan to have one department attend each month when they need feedback for any projects, initiatives, or programs.

Currently reviewing top performing service areas and focusing on service areas that are lowest performing. Focusing our attention on our medical practice offices and our outpatient services which involve, registration, laboratory, and diagnostic imaging services.

Advisory council recommended we encourage all patients to return their satisfaction surveys. Scripting sent to all leaders to share with staff to encourage patients and families to send back their feedback if they receive a survey.

Communication is a large part of a care experience. Empathy should be shown at every touch point as we do not know exactly why the patients are here, but typically there is a lot of anxiety around any test, treatment, or office visit.

Tahoe Forest Hospital Quality website was updated with PFAC input.

Janet Van Gelder, Hilary Ward, and Jim Sturtevant presented the Just Culture and High Reliability journey at the November 2019 meeting. Dawn Colvin, Patient Safety Officer, will review the Beta Heart and Disclosure program in January 2020.

Plan to send one or two PFAC members to the Patient and Family Centered Care annual conference in Los Angeles in February, 2020. Pati Johnson and I attended in February 2019.

Next Meeting January 21, 2020

Beta HEART Progress Report as of January 2020

Domain	Incentive/ Renewal Credit	% Completed	Estimated date for completion	Comments
Culture of Safety: A process for measuring safety culture and staff engagement	2%	100%	Completed May 2019	Validation completed in May 2019 resulting in 2% reduction/incentive. SCORE survey year 2 completed with 83% response rate. Excellent improvement in all domains of SCOR survey for TFHD. Patient Safety Officer (PSO) has conducted debriefings and worked with leadership team/all departments to set goals for improvement.
Rapid Event Response and analysis: A formalized process for early identification and rapid response to adverse events that includes an investigatory process that integrates human factors and systems analysis while applying Just Culture principles	2%	75%	Spring 2020	Many components in place. Need to formalize several areas including cognitive interviewing training (required by Beta); formalize process diagram for event response. Working with Reliability Management Team to coordinate process language. Beta has changed some of the validation requirements to include an actual event/case review with external committee via Beta.
Communication and transparency: A commitment to honest and transparent communication with patients and family members after an adverse event	2%	95%	Validation planned for Spring 2020	Many components in place. Revised disclosure checklist to reflect best practices. Quality team will take the lead on most major disclosures. October 23rd communication training attended by over 30 people and was well received. Developed guidelines for leadership to perform internal/small issue disclosures. Plan to schedule Beta Validation for Spring 2020.
Care for the Caregiver: An organizational program that ensures support for caregivers involved in an adverse event	2%	85%	Spring 2020	Lauren Caprio (HR) and Dawn Colvin (PSO) are co-chairing Peer Support: a team to formalize process including staff training, peer supporter team, process for initiating. Peer Support name and logo, policy, algorithm for initiation, and some education finalized. Pacesetter article and Lunch and Learn. Interviewing applicants for Peer Supporters with staff training planned for March 2020. Joined Northern Nevada Peer Support Network, a 1st responder network.
Early Resolution: A process for early resolution when harm is deemed the result of inappropriate care or medical error	2%	70%	Summer/ Fall 2020	Many components in place. This domain typically is the final one to validate as it includes components from the other 4 domains. TFHD is participating as a test site for the Beta HEART dashboard, which will formalize data collection for the HEART program. Beta has not released dashboard yet; has also added several new components that must be met before validation

Quality Assessment_ Performance Improvement (QA_PI) Plan, AQPI-05

PURPOSE:

The purpose of the Quality Assessment/Performance Improvement (QA/PI) plan is to provide a framework for promoting and sustaining performance improvement at Tahoe Forest Health System, in order to improve the quality of care and enhance organizational performance. 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 High Reliability tenets 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.

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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 2020 performance improvement priorities are based on the principles of STEEEP™, (Safe, Timely, Effective, Efficient, Equitable, Patient Centered Care) and the Quadruple Aim:
   1. Improving the patient experience of care (including quality and satisfaction);
   2. Improving the health of populations;
   3. Reducing the per capita cost of health care;
   4. Staff engagement and joy in work.

B. Priorities identified include:
   1. Exceed national benchmark with quality of care and patient satisfaction metric results with a focus on process improvement and performance excellence
      a. Striving for the Perfect Care Experience
      b. Identify and promote best practice and evidence-based medicine
   2. Ongoing survey readiness, and compliance with federal and state regulations, resulting in a successful triennial Healthcare Facilities Accreditation Program (HFAP) survey
   3. Sustain a Just Culture philosophy that promotes a culture of safety, transparency, and system improvement
      a. Continued participation in Beta HEART (Healing, Empathy, Accountability, Resolution, Trust) program
      b. Conduct annual Culture of Safety SCORE (Safety, Culture, Operational, Reliability, and Engagement) survey
      c. Continued focus on the importance of event reporting
   4. Focus on our culture of safety, across the entire Health System, utilizing High Reliability Organizational thinking
      a. Proactive, not reactive
      b. Focus on building a strong, resilient system
      c. Understand vulnerabilities
      d. Recognize bias
      e. Efficient resource management
      f. Evaluate system based on risk, not rules
   5. 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.
   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

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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 and performance improvement initiatives. Each strategic priority is driven by leadership oversight and teams developed to ensure improvement and implementation (Attachment A -- Quality Initiatives).

ORGANIZATION FRAMEWORK

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

Governing Board

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

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

Administrative Council

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

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

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

Board Quality Committee

The Board Quality Committee is to provide oversight for the Health System QA/PI Plan and set expectations of quality care, patient safety, environmental safety, and performance improvement throughout the organization. The committee will monitor the improvement of care, treatment and services to ensure that it is safe, timely, effective, efficient, equitable and patient-centered. They will oversee and

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be accountable for the organization's participation and performance in national quality measurement efforts, accreditation programs, and subsequent quality improvement activities. The committee will assure the development and implementation of ongoing education focusing on service and performance excellence, risk-reduction/safety enhancement, and healthcare outcomes.

Medical Executive Committee

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

Department Chairs of the Medical Staff

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

Medical Staff

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

Hospital Management (Directors, Managers, and Supervisors)

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

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improvement activities for department-specific performance improvement initiatives;

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

Employees

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

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

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

PERFORMANCE IMPROVEMENT STRUCTURE

Medical Staff Quality Assessment Committee

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

The Medical Staff Quality Assessment Committee:

A. Annually review and approve the Medication Error Reduction Plan (MERP), Infection Control Plan, Environment of Care Management Program, Utilization Review Plan, Risk Management Plan, Trauma Performance Improvement Plan, and the Patient Safety Plan.

B. Regularly reviews progress to the aforementioned plans.

C. Reviews quarterly quality indicators to evaluate patient care and delivery of services and takes appropriate actions based on patient and process outcomes;

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

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

F. Reviews and approves chartered Performance Improvement Teams as recommended by the

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Performance Improvement Committee (PIC). Not all performance improvement efforts require a chartered team;

G. Reviews progress reports from chartered teams and assists to address and overcome identified barriers;
H. Reviews summaries and recommendations of Event Analysis/Root Cause Analysis (RCA) and Failure Mode Effects Analysis (FMEA) activities.
I. Oversees the radiation safety program, including nuclear medicine and radiation oncology and evaluates the services provided and make recommendations to the MEC.
J. Oversees the Trauma Program and monitors compliance with the Trauma Performance Improvement plan.

Performance Improvement Committee (PIC)

A. Medical Staff Quality Assessment Committee provides direct oversight for the PIC. PIC is an executive committee with departmental representatives within the Tahoe Forest Health System, presenting their QA/PI findings as assigned. The goal of this committee is to achieve optimal patient outcomes by making sure that all staff participate in performance improvement activities. Departmental Directors, or their designee, review assigned quality metrics biannually at the PIC (See Attachment C – QA PI Reporting Measures). Performance improvement includes collecting data, analyzing the data, and taking action to improve. Director of Quality and Regulations is responsible for processes related to this committee.
B. The Performance Improvement Committee will:
    1. Oversee the Performance Improvement activities of TFHS including data collection, data analysis, improvement, and communication to stakeholders
    2. Set performance improvement priorities and provide the resources to achieve improvement
    3. Reviews requests for chartered Performance Improvement Teams. Requests for teams may come from committees, department or individual employees. Not all performance improvement efforts require a chartered team;
    4. Report the committee's activities quarterly to the Medical Staff Quality Committee.

SCIENTIFIC METHOD FOR IMPROVEMENT ACTIVITIES

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

Performance Improvement Teams

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

PERFORMANCE IMPROVEMENT

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EDUCATION

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

PERFORMANCE IMPROVEMENT PRIORITIES

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

DESIGNING NEW AND MODIFIED

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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.

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a. The process is assessed to identify steps that may cause undesirable variations, or "failure modes".
b. For each identified failure mode, the possible effects, including the seriousness of the effects on the patient are identified and the potential breakdowns for failures will be prioritized.
c. Potential risk points in the process will be closely analyzed, including decision points and patient's moving from one level of care to another through the continuum of care.
d. For the effects on the patient that are determined to be "critical", an event analysis/root cause analysis is conducted to determine why the effect may occur.
e. The process will then be redesigned to reduce the risk of these failure modes occurring or to protect the patient from the effects of the failure modes.
f. The redesigned process will be tested and then implemented. Performance measurements will be developed to measure the effectiveness of the new process.
g. Strategies for maintaining the effectiveness of the redesigned process over time will be implemented.

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

DATA COLLECTION

A. Tahoe Forest Health System chooses processes and outcomes to monitor based on the mission and scope of care and services provided and populations served. The goal is 100% compliance with each identified quality metric. Data that the organization considers for the purpose of monitoring performance includes, but is not limited to, adverse patient events, which includes the following:
1. Medication therapy
2. Adverse event reports
3. National Quality forum patient safety indicators
4. Infection control surveillance and reporting
5. Surgical/invasive and manipulative procedures
6. Blood product usage, including transfusions and transfusion reactions
7. Data management
8. Discharge planning
9. Utilization management
10. Complaints and grievances
11. Restraints/seclusion use
12. Mortality review
13. Medical errors including medication, surgical, and diagnostic errors; equipment failures, infections, blood transfusion related injuries, and deaths due to seclusion or restraints
14. Needs, expectations, and satisfaction of individuals and organizations served, including:
    a. Their specific needs and expectations
    b. Their perceptions of how well the organization meets these needs and expectations
    c. How the organization can improve patient safety?
    d. The effectiveness of pain management
15. Resuscitation and critical incident debriefings
16. Unplanned patient transfers/admissions

17. Medical record reviews
18. Performance measures from acceptable data bases/comparative reports, i.e., RL Datix Event Reporting, Quantros RRM, NDNQI, HCAHPS, Hospital Compare, QHi, CAHEN 2.0, and Press Ganey
19. Summaries of performance improvement actions and actions to reduce risks to patients

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

AGGREGATION AND ANALYSIS OF DATA

A. Tahoe Forest Health System believes that excellent data management and analysis are essential to an effective performance improvement initiative. Statistical tools are used to analyze and display data. These tools consist of dashboards, bar graphs, pie charts, run charts (SPC), histograms, Pareto charts, control charts, fishbone diagrams, and other tools as appropriate. All performance improvement teams and activities must be data driven and outcome based. The analysis includes comparing data within our organization, with other comparable organizations, with published regulatory standards, and best practices. Data is aggregated and analyzed within a time frame appropriate to the process or area of study. Data will also be analyzed to identify system changes that will help improve patient safety and promote a perfect care experience (See Attachment D for QI PI Indicator definitions).
B. The data is used to monitor the effectiveness and safety of services and quality of care. The data analysis identifies opportunities for process improvement and changes in patient care processes. Adverse patient events are analyzed to identify the cause, implement process improvement and preventative strategies, and ensure that improvements are sustained over time.
C. Data is analyzed in many ways including:
   1. Using appropriate performance improvement problem solving tools
   2. Making internal comparisons of the performance of processes and outcomes over time
   3. Comparing performance data about the processes with information from up-to-date sources
   4. Comparing performance data about the processes and outcomes to other hospitals and reference databases
D. Intensive analysis is completed for:
   1. Levels of performance, patterns or trends that vary significantly and undesirably from what was expected
   2. Significant and undesirable performance variations from the performance of other operations
   3. Significant and undesirable performance variations from recognized standards
   4. A sentinel event which has occurred (see Sentinel Event Policy)
   5. Variations which have occurred in the performance of processes that affect patient safety
   6. Hazardous conditions which would place patients at risk
   7. The occurrence of an undesirable variation which changes priorities
E. The following events will automatically result in intense analysis:
   1. Significant confirmed transfusion reactions

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

REPORTING

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

CONFIDENTIALITY AND CONFLICT OF INTEREST

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

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

ANNUAL ASSESSMENT

A. The Critical Access Hospital (CAH) and Rural Health Clinic (RHC) Quality Assessment Performance Improvement program and the objective, structure, methodologies, and results of performance improvement activities will be evaluated at least annually (CMS485.641(b)(1)).
B. The evaluation includes a review of patient care and patient related services, infection control, medication administration, medical care, and the Medical Staff. More specifically, the evaluation includes a review of the utilization of services (including at least the number of patients served

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and volume of services), chart review (a representative sample of both active and closed clinical records), and the Health System policies addressing provision of services.

C. The purpose of the evaluation is to determine whether the utilization of services is appropriate, policies are followed, and needed changes are identified. The findings of the evaluation and corrective actions, if necessary, are reviewed. The Quality Assessment program evaluates the quality and appropriateness of diagnoses, treatments furnished, and treatment outcomes.
D. An annual report summarizing the improvement activities and the assessment will be submitted to the Medical Staff Quality Committee, the Medical Executive Committee, and the Board of Directors.

PLAN APPROVAL

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

Related Policies/Forms:

Medication Error Reduction Plan, APH-34

Medication Error Reporting, APH-24

Infection Control Plan, AIPC-64

Environment of Care Management Program, AEOC-908

Utilization Review Plan (UR), DCM-1701

Risk Management Plan , AQPI-04

Patient Safety Plan, AQPI-02

Emergency Operations Plan (Comprehensive), AEOC-17

Trauma Performance Improvement Plan

Discharge Planning, ANS-238

References:

HFAP and CMS

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WHITE PAPER

Framework for Effective Board Governance of Health System Quality

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AN IHI RESOURCE

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AUTHORS:

Elizabeth Daley Ullem, MBA: *Faculty Lead, IHI; President, Quality and Safety First*

Tejal K. Gandhi, MD, MPH, CPPS: *Chief Clinical and Safety Officer, IHI; President, IHI Lucian Leape Institute*

Kedar Mate, MD: *Chief Innovation and Education Officer, IHI*

John Whittington, MD: *Senior Fellow, IHI*

Marina Renton: *Research Assistant, IHI*

Joellen Huebner: *Senior Project Manager, IHI*

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For more than 25 years, the Institute for Healthcare Improvement (IHI) has used improvement science to advance and sustain better outcomes in health and health systems across the world. We bring awareness of safety and quality to millions, accelerate learning and the systematic improvement of care, develop solutions to previously intractable challenges, and mobilize health systems, communities, regions, and nations to reduce harm and deaths. We work in collaboration with the growing IHI community to spark bold, inventive ways to improve the health of individuals and populations. We generate optimism, harvest fresh ideas, and support anyone, anywhere who wants to profoundly change health and health care for the better.

The ideas and findings in these white papers represent innovative work by IHI and organizations with whom we collaborate. Our white papers are designed to share the problems IHI is working to address, the ideas we are developing and testing to help organizations make breakthrough improvements, and early results where they exist.

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Executive Summary

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

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

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

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

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

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

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

Background

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

What to Govern as Quality: Expanding from Safety to STEEEP

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

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

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

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

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

Call to Action

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

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

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

Assessment of Current Governance Practices and Education

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

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

Research and Landscape Scan Highlights

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

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

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

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

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

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

Barriers to Governance of Quality

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

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

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

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

Current State of Board Work and Education in Health System Quality

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

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

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

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

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

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

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

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

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

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

Framework for Governance of Health System Quality

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

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

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

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

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

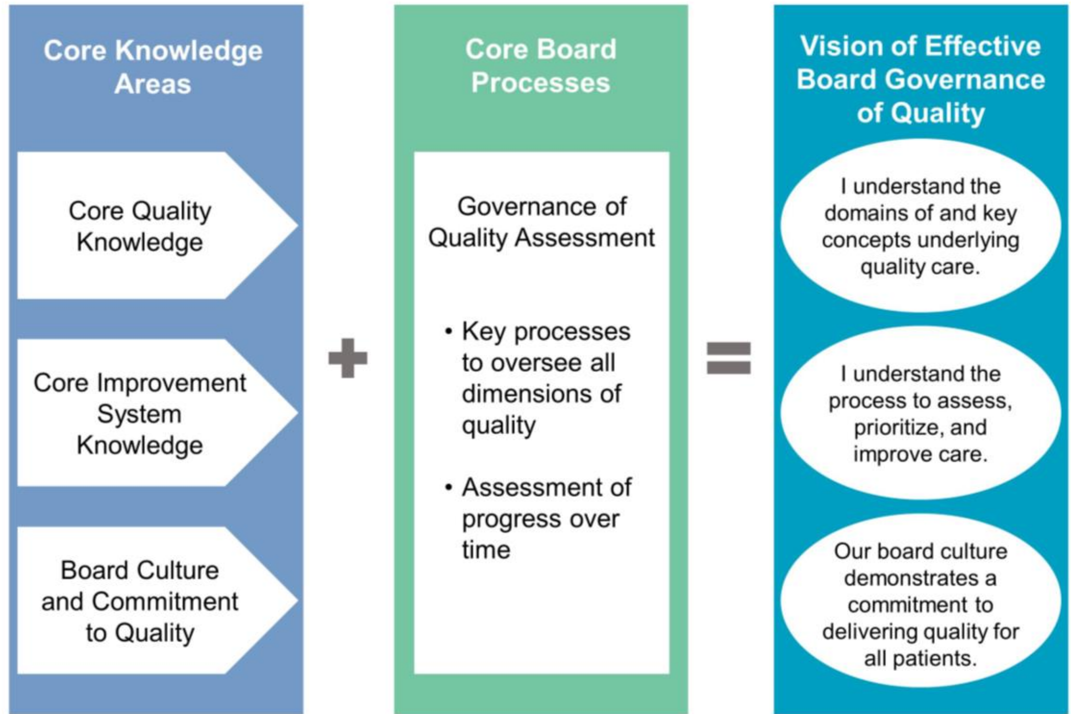
I understand the domains of and key concepts underlying quality care.

I understand the process to assess, prioritize, and improve care.

Our board culture demonstrates a commitment to delivering quality for all patients.

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

Figure 2. Framework for Governance of Health System Quality



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

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

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

Patient-Centered Depiction of Quality

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

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

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

Keep Me Safe
*Safe
Help Me Stay Well
Help Me Navigate My Care
*Timely, Efficient
Treat Me with Respect
*Equitable, Patient centered
Provide Me with the Right Care
*Effective
Patient

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

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

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

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

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

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

GQA Core Processes and Scoring

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

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

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

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

Bringing the GQA to the Boardroom

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

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

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

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

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

Governance of Quality Assessment (GQA) Tool

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

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

Instructions

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

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

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

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

Governance of Quality Assessment Tool (continued)

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

Governance of Quality Assessment Tool (continued)

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

Governance of Quality Assessment Tool (continued)

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

Governance of Quality Assessment Tool (continued)

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

Governance of Quality Assessment Tool (continued)

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

Governance of Quality Assessment Tool (continued)

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

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

Interpreting the Overall Governance of Quality Assessment Score

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

Using GQA Results to Plan Next Steps

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

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

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

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

Conclusion

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

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

Appendix A: Support Guides

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

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

- Support Guide: Core Quality Knowledge
- Support Guide: Core Improvement System Knowledge
- Support Guide: Board Culture and Commitment to Quality

Support Guide: Core Quality Knowledge

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

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

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

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

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

Table 1. Foundational Concepts for Board Core Quality Knowledge

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

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

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

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

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

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

Support Guide: Core Improvement System Knowledge

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

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

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

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

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

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

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

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

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

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

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

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

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

Support Guide: Board Culture and Commitment to Quality

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

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

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

Set Expectations and Prioritize Quality

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

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

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

Build Knowledge Competency and Define Oversight Responsibility of Quality

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

Create a Culture of Inquiry

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

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

Be Visible in Supporting Quality

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

Focus on the Patient

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

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

Appendix B: IHI Lucian Leape Institute Expert Meeting Attendees

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

July 12, 2018

- Paul Anderson, Trustee, University of Chicago Medical Center
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- Maulik Joshi, DrPH, Chief Operating Officer, Executive Vice President, Integrated Care, Anne Arundel Medical Center
- Gary S. Kaplan, MD, FACMPE, Chairman and CEO, Virginia Mason Health System; Chair, IHI Lucian Leape Institute; Board Member, Institute for Healthcare Improvement
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- Sam R. Watson, MSA, MT(ASCP), CPPS, Senior Vice President, Patient Safety and Quality, and Executive Director, MHA Keystone Center for Patient Safety and Quality, Michigan Health & Hospital Association; Board Member, Institute for Healthcare Improvement
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- Kevin B. Weiss, MD, MPH, Senior Vice President, Institutional Accreditation, Accreditation Council for Graduate Medical Education
- David M. Williams, PhD, Senior Lead, Improvement Science and Methods, Institute for Healthcare Improvement
- Isis Zambrana, Associate Vice President, Chief Quality Officer, Jackson Health System

Appendix C: Members of the IHI Lucian Leape Institute

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

Emeritus Members

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

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

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

Tahoe Forest Health System Quality & Regulations

Janet Van Gelder, RN, DNP, CPHQ

Director of Quality & Regulations

What is Health Care Facilities Accreditation (HFAP)?

- nationally recognized healthcare facility accreditation organization, with deeming authority from the Centers for Medicare and Medicaid Services (CMS)
- provide accreditation to **<u>all</u>** hospitals, ambulatory care/surgical facilities, mental health facilities, physical rehabilitation facilities, clinical laboratories, and critical access hospitals
- triennial unannounced survey of the CMS Conditions or Participation (COP) standards

Survey Process

- Survey teams generally consist of three surveyors: A physician who serves as team captain, a Registered Nurse, and a hospital administrator
- Unannounced two day survey at TFH and IVCH at different times
- Will observe & ask physicians & staff questions about our policies and processes

Preparation

- Review HFAP Manual in G:Public:Accreditation Folder:HFAP
- Prepare Chapter binder or electronic folder with supporting documents
- Assess department for compliance (outdates, biomedical stickers, hallways clear, etc.)
- Keep performance excellence board up to date
- Review survey process at every staff meeting

HFAP Education

- Review survey tidbit trifold and pocket reference booklet
- Review departmental Performance Excellence board for QA/PI activities
- Attend the HFAP Education Fair
  - IVCH Community Room on Wednesday, April 1st from 0700-1100
  - TFH Eskridge Lobby Conference Room on Thursday, April 2nd from 0700-1900

Regulatory: Licensing and Certification

- Health Care Facilities Accreditation (HFAP)
  - Deemed accreditation from CMS
  - TFH, IVCH, Clinics, Cancer Center
- Centers for Medicare and Medicaid Services (CMS)
  - California Department of Health Services represents for CMS survey & Title 22
    - ECC SNF, Home Health, Hospice
- Nevada Bureau of Health Care Quality & Compliance (HCQC)
  - IVCH, Home Health, Hospice

Possible Observations

- Handwashing
- Wearing name badge
- Infection control techniques
- Time out procedure
- Securing & labeling medications
- Medical Record security & confidentiality
- Accessing Epic & charting

Possible Questions

- What do you do if there is a fire?
- What do you do if there is a cardiac arrest?
- What are your emergency codes?
- What is the emergency phone number?
- What Quality/Performance Improvement activities have you worked on recently?
- Can you show me how to find a policy? Physician privileges?
- How do you request an Ethics Committee consultation?
- What is the process to report child/elder abuse or domestic violence?

Quality & Regulation Staff

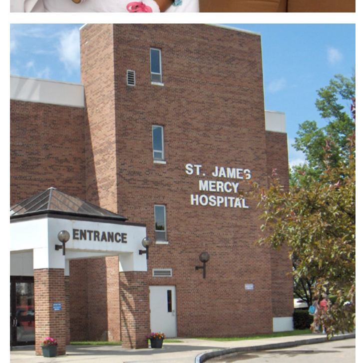
- Dawn Colvin, MPT, Patient Safety Officer (ext. 6423)
- Joshua Fetbrandt, MS, Quality Specialist (ext. 3272)
- Todd Johnson, BSN, JD, Risk Manager/Privacy Officer (ext. 6637)
- Svieta Schopp, RN, MSN, Infection Preventionist (ext. 8231)
- Peter Taylor, MD, Quality Medical Director
- Lorna Tirman, RN, PhD, Patient Experience (ext. 6567)
- Janet Van Gelder, RN, DNP, Director (ext. 6629)

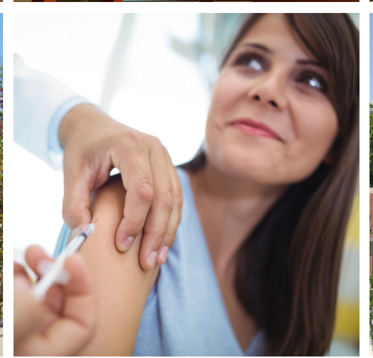
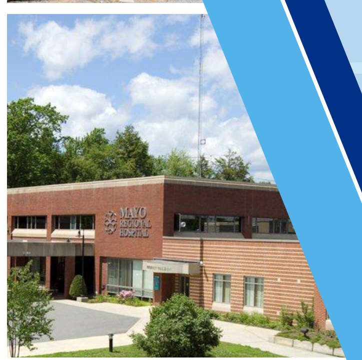
American Hospital Association™

Advancing Health in America

RURAL REPORT

Challenges Facing Rural Communities and the Roadmap to Ensure Local Access to High-quality, Affordable Care



Challenges Facing Rural Communities and the Roadmap to Ensure Local Access to High-quality, Affordable Care

Nearly 20 percent of Americans live in rural areas and depend on their hospitals as important – and often only – sources of care in their communities.[1,2] Rural hospitals provide access to care close to home and improve the health and well-being of the patients and communities they serve. The availability of local, timely access to care saves lives and reduces the added expense, lost work hours and inconvenience of traveling to facilities farther away.

> **These more vulnerable populations are at increased risk of losing access to some types of health care, exacerbation of health disparities and loss of hospital and other types of local employment.**
>
> – George H. Pink, Ph.D., Research Fellow, Sheps Center for Health Services Research, University of North Carolina (UNC), as quoted in Health Resources & Services Administration eNews, "Hospital closings likely to increase" (October 2017)

Rural hospitals also serve as economic anchors in their communities; they provide both direct employment opportunities[3] and indirect reinforcement of the local economy through the purchase of goods and services from other private sector entities.[4] The availability of local access to health care is an important factor for businesses considering whether to invest or locate in a particular area. Moreover, private sector employment generated by rural hospitals supports a healthy tax base, which funds services such as public education, fire, police and road maintenance.

Although rural hospitals endeavor to meet the health care needs in their communities, many struggle to address the persistent challenges of providing health care in rural America, such as low patient volumes and geographic isolation. At the same time, they are working to manage more recent and emergent challenges, including economic fluctuations, increased regulatory burden, and the opioid epidemic. In response to these difficulties, some hospitals have elected to merge with larger health systems, engage in other types of affiliations or partnerships, or modify their service offerings, in order to stay viable and protect health care access for their communities. In fact, there have been 380 rural hospital mergers between 2005 and 2016, with some rural hospitals merging more than once.[5]

While some hospitals are continuing to thrive, others find that the cumulative burden of persistent, recent and emerging challenges threaten their ability to maintain access to services. In fact, the North Carolina Rural Health Research Program reports that as of December 2018, 95 rural hospitals have closed since 2010 (Figure 1). Moreover, the Government Accountability Office reports that more than twice the number of hospitals have closed between

Figure 1: Rural Hospital Closures Since 2010

December 2018

Source: NC Rural Health Research Program. (2018). 95 Rural Hospital Closures: January 2010 – Present. The Cecil G. Sheps Center for Health Services Research, University of North Carolina; *www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/*

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2013 and 2017 than in the previous five-year period, indicating a worsening trend.[6] These closures stem from numerous factors, including failure to recover from the recession, population demographic trends, ongoing financial struggles and decreased demand for inpatient services.[7] The effects of these closures vary: in some cases, hospital closures resulted in a noticeable reduction in a particular set of services (e.g., elimination of obstetric services or conversion of a full-service acute care hospital to an urgent care center), while others led to a complete elimination of local access to care. But, in all cases, local residents are put in a position of having to seek alternatives – sometimes long distances away – to obtain the care they need.

> **Losing an employer of 150 people with good jobs is like losing a manufacturing plant. Hospitals are usually the largest, or the second-largest, employer in a community. That's something that's easy to lose sight of because we think of this from a health standpoint. But the effects are wide-ranging when a hospital closes.**
>
> – Mark Holmes, Director, Sheps Center for Health Services Research, UNC, as quoted in PBS.org article, "Rural hospitals rely on Medicaid to stay open, study shows" (Jan. 9, 2018)

Many rural hospitals, especially those with very limited resources, become overburdened as challenges intensify, accumulate, and compound each other. Moreover, the issues of today may hinder rural providers' preparedness for the challenges of tomorrow.

In this report, we examine the persistent, recent, and emergent challenges facing rural hospitals and communities; and recommend updates to existing federal policies and areas for new federal investment to support rural hospitals and communities to ensure access to high-quality, affordable, and efficient health care. To be sure, the policy environment for rural providers is not limited to federal activities; laws and regulations at the state and local levels play critical roles in shaping the rural health care context. However, this report focuses on federal policies and investments in light of their nationwide impact and reach. A complete listing of AHA policy priorities and recommendations for America's rural hospitals and communities is available in the 2018 Rural Advocacy Agenda, 2018 Advocacy Agenda, and the Task Force on Ensuring Access in Vulnerable Communities Report. All are available at *www.aha.org*.

Persistent, Recent and Emergent Challenges Facing Rural Communities

Rural hospitals have always faced a unique set of circumstances, including a challenging payer and patient mix and geographic isolation. In the 1990s and early 2000s, Congress sought to help account for these circumstances and address the growing number of rural hospital closures by creating several special designations and payment programs – the low-volume adjustment, Medicare-dependent hospital program, and ambulance add-on adjustment, among others – which provide enhanced reimbursement under the Medicare program. The designations and programs that remain today are identified and defined in the Appendix. While these programs remain critical to the financial viability of many rural hospitals, they no longer provide the financial predictability they once did, and rural hospitals continue to grapple with an increasing set of new and ongoing challenges.

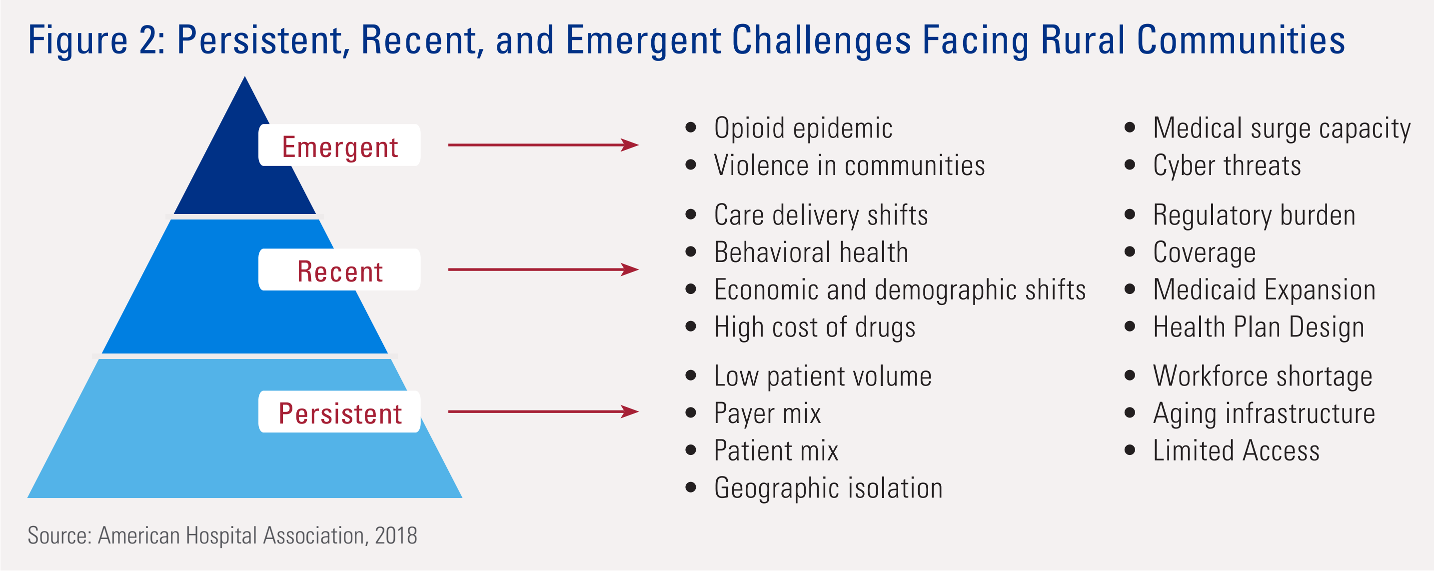
Persistent Challenges

Low Patient Volume. Due to low population density in rural areas, hospitals lack scale to cover the high fixed operating costs. In fact, as early as 1990, the Government Accountability Office found that

low occupancy was associated with higher risk of hospital closure.[8] Given the clear link between volume and hospital viability, Congress established the Low-volume Hospital Adjustment (LVA) program in 2003. However, the program continues to face threats of retrenchment despite the effectiveness of LVA in assisting hundreds of rural hospitals (excluding Critical Access Hospitals [CAHs], which are not eligible).[9]

Low patient volume, in addition to other rural provider challenges, also can be a hindrance to participating in performance measurement and improvement activities. Rural providers may not be able to obtain statistically reliable results for some performance measures without meeting certain case thresholds, making it difficult to identify areas of success or areas for improvement. Additionally, quality programs often require reporting on measures that are not relevant to the low-volume, rural context. Given these issues, the Centers for Medicare Medicaid Services (CMS) tasked the National Quality Forum to identify a core set of rural-relevant measures and develop rural-focused recommendations on measuring and improving access to care. The final report may be found at *www.qualityforum.org*.

Figure 2: Persistent, Recent, and Emergent Challenges Facing Rural Communities



Source: American Hospital Association, 2018

Challenging Payer Mix. Rural hospitals are more likely to serve a population that relies on Medicare and Medicaid. However, these programs reimburse less than the cost of providing care, making rural hospitals especially vulnerable to policy changes in payment of services. Specifically, in 2017 Medicare and Medicaid made up 56 percent of rural hospitals' net revenue.[10] Yet, overall hospitals receive payment of only 87 cents for every dollar spent caring for Medicare and Medicaid patients.[11] Notably, the Medicare Payment Advisory Commission (MedPAC), found in its March 2018 report to Congress that rural hospitals (excluding CAHs) Medicare margin was -7.4 percent.

Dependence on government programs also makes rural hospitals vulnerable to reductions and shifts in government funds, such as the Affordable Care Act (ACA)-mandated productivity cut, which is a 0.8 percent reduction for inpatient payments in fiscal year 2019. Additionally, Medicare sequestration has reduced payments to all hospitals by 2 percent, including CAHs, which see a reduction in payment from 101 percent to 99 percent of allowable costs. Meanwhile, hospitals in states that did not expand Medicaid under the ACA have higher rates of unrecoverable debt and charity care, as well as higher rates of uninsured patients.[12]

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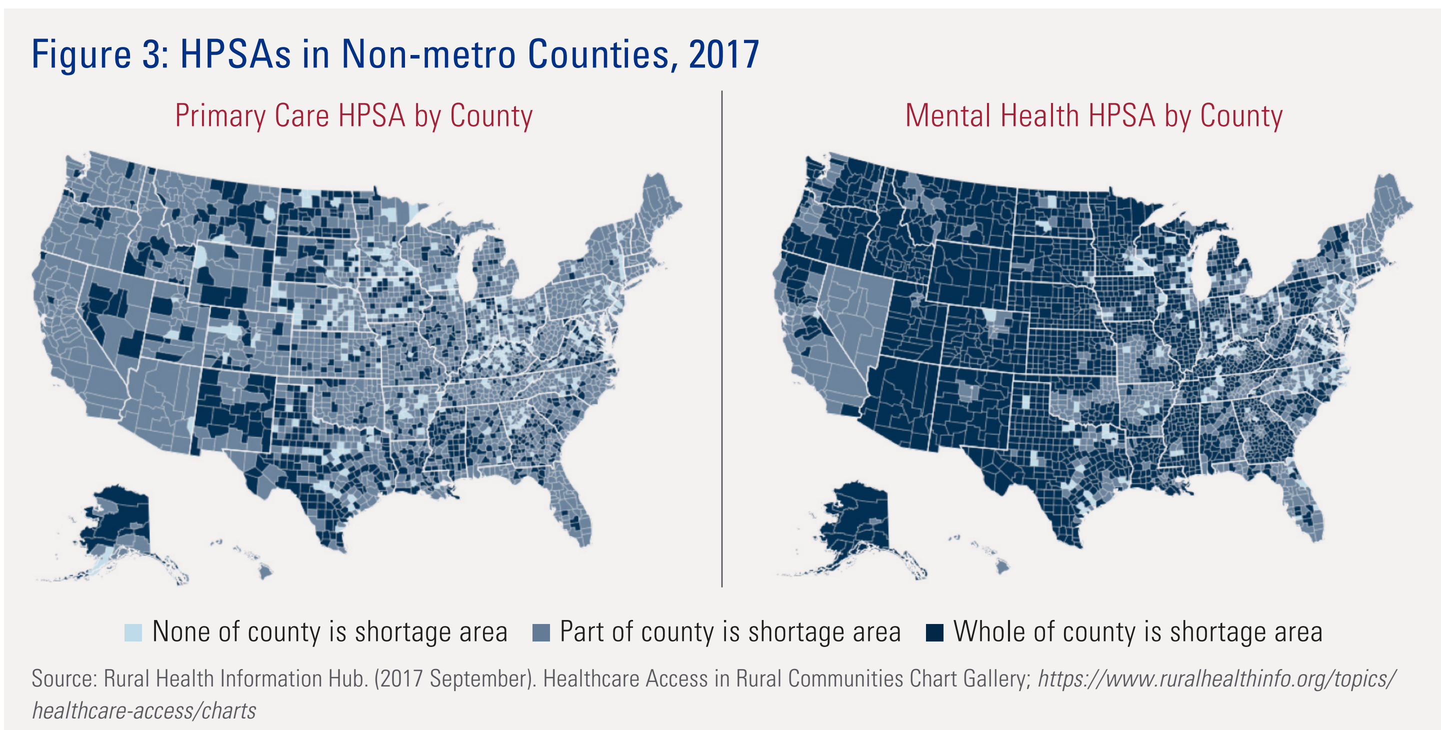
Challenging Patient Mix. Rural hospitals treat a patient population that is often older, sicker and poorer compared to national averages. For example, although less than 14 percent of the nation's population is over age 65, this group makes up more than 18 percent of residents in rural areas.[13] In 2016, the Robert Wood Johnson Foundation published its County Health Rankings Key Findings Report, which showed that across health behaviors, clinical care, and social and economic factors, rural counties performed worse in nearly all categories: adult smoking, adult obesity, teen births, uninsured rates, preventable hospitals stays, education, children living in poverty, and injury deaths. These characteristics underscore the importance of local access to care and the need for resources to support the changing needs of the community.

> **"Rural America is a little bit older, a little bit sicker, a little bit poorer.**
>
> – Anand Parekh M.D., Chief Medical Advisor, Bipartisan Policy Center, as quoted in the Advisory Board Daily Briefing (March 3, 2018)

Geographic Isolation. Rural communities are often located away from population centers and other health care facilities. According to a recent Pew Research Center survey, among the quarter of rural Americans traveling the longest to reach an acute care facility, the average travel time is 34 minutes by car.[14] Beyond this, in some rural communities, inclement weather or hazardous terrain can make transportation impossible or unsafe. And for many, public transportation is not reliable or available at all. Geographic challenges such as these can cause patients to delay or forego health care services,[15] which can increase the complexity and overall cost of care once services are delivered.[16] Isolation also may be a barrier to professional development and continuing clinical education.

Workforce Shortages. Recruitment and retention of health care professionals is an ongoing challenge and expense for rural hospitals. While almost 20 percent of the U.S. population lives in rural areas, less than 10 percent of U.S. physicians practice in these communities.[17] Figure 3 shows how widespread Health Professional Shortage Areas (HPSAs) are across rural America.

Figure 3: HPSAs in Non-metro Counties, 2017



Source: Rural Health Information Hub. (2017 September). Healthcare Access in Rural Communities Chart Gallery; *https://www.ruralhealthinfo.org/topics/healthcare-access/charts*

Primary care is experiencing widespread professional shortages in rural areas. As of November 2018, two-thirds of the nation's 6,941 primary care Health Professional Shortage Areas (HPSAs) were in rural or partially rural areas.[18]

> **There is no community (public) mental health care, and often there are no relevant hospital services within a reasonable distance. So, people are just left on their own.**
>
> – www.CNN.com, "There's a severe shortage of mental health professionals in rural areas. Here's why that's a serious problem" (June 22, 2018)

Nurse practitioners, midwives and physician assistants have helped to address the shortages. In fact, nurse practitioners and physician assistants currently account for 19 percent and 7 percent, respectively, of the primary care workforce and contribute substantially to the total supply of primary care visits.[19] However, many state licensure laws limit the ability of advanced practice clinicians to practice at the top of their license, thus limiting the services they may offer to patients. Physician supervision regulations also may hinder maximal use of advanced professional staff.

Clinical workforce shortages exist across specialties, but the limited number of behavioral health providers is particularly striking.[20] In fact, a 2016 JAMA study found that mental health conditions were responsible for nearly 80 percent of telemedicine visits among rural Medicare beneficiaries from 2004-2013, highlighting both the scarcity of behavioral health specialists and a need for innovative solutions.[21]

In addition, non-clinical staff to support rural health care activities also are in short supply. A 2018 Medical Group Management Association Stat poll found that more than 60 percent of respondents indicated

Figure 4: AHA Task Force on Vulnerable Communities Essential Health Care Services

Emerging Strategy \ Essential Health Care Service	Primary Care	Psychiatric and substance use treatment services	ED and observation care	Prenatal care	Transportation	Diagnostic services	Home care	Dentistry services	Robust referral structure
Addressing the Social Determinants of Health					x				x
Global Budget Payments	x	x	x	x	x	x	x		x
Inpatient/Outpatient Transformation Strategy	x	x	x	x		x			x
Emergency Medical Center	x		x		x	x			x
Urgent Care Center	x					x			x
Virtual Care Strategies	x	x	x						x
Frontier Health System	x	x	x	x	x	x	x		x
Rural Hospital-Health Clinic Strategy	x	x	x	x		x		x	x
Indian Health Services Strategies	x	x	x	x	x	x	x		x

Source: American Hospital Association. (2018). Access to Care in Vulnerable Communities; *www.aha.org/vulnerablecommunities*

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that their organization had a shortage of qualified applicants for non-clinical positions in the past year.[22] Difficulty in recruiting to rural areas was noted as one of the reasons for the hiring deficit.[23]

Limited Access to Essential Services. Workforce shortages, geographic isolation and other persistent challenges facing rural communities contribute to low availability of services, including primary care, behavioral health services and dental care. For example, while the average rate of primary care physicians (PCPs) across the United States is approximately 80 PCPs per 100,000 people, rural areas experience a rate of only 68 PCPs per 100,000 people.[24] Insufficient access to primary care and other essential services leads to poorer health outcomes and increases the likelihood of more costly, higher acuity episodes at the time of treatment. Moreover, limited transportation options in rural areas exacerbate access challenges, contributing to delayed (or forgone) medical attention and subsequent disease progression.[25]

In recognition of the challenges facing vulnerable communities and the need for new strategies to address them, in 2015 the AHA Board of Trustees created the Task Force on Ensuring Access in Vulnerable Communities. The Task Force identified a set of essential services, illustrated in Figure 4, that should be available in all communities. These services, along with strategies to help to rural communities maintain access to them, are described in the Task Force's report, which is available at *www.aha.org/ensuringaccess*.

Aging Infrastructure and Access to Capital. Many rural hospitals were constructed following the passage of the Hill-Burton Act of 1947, which provided grants and loans for the construction and modernization of hospitals and other health care facilities. Currently, many rural hospitals need to update their facilities and services to better align with how care is delivered in the 21st century. Yet, narrow financial margins limit rural hospitals' ability to retain earnings and secure access to capital or qualify for U.S. Department of Agriculture or the U.S. Department of Housing and Urban Development mortgage guarantees. Without some or all of these resources, rural hospitals are unable to update facilities and purchase needed equipment. Moreover, the Tax Cuts and Jobs Act of 2017 included changes that could affect interest rates for tax-exempt bonds, making borrowing more expensive for hospitals.[26]

Recent Challenges

Changes in health care delivery, the high cost of prescription drugs and other challenges have emerged recently, requiring flexibility, additional resources and new strategies for hospitals to meet the needs of their communities.

Changes in Health Care Delivery. Across the United States, numerous health care services that have previously only been provided on an inpatient basis are now offered in outpatient settings. This shift reflects advancements in clinical practices, sophisticated technologies, innovations and changes in patient preferences. Between 2006 and 2016, outpatient visits have risen by nearly 50 percent among Medicare beneficiaries across the country, while inpatient discharges have dropped by more than 20 percent.[27] On the whole, rural hospitals are experiencing this broader trend: during the past three years, total inpatient admissions in rural hospitals have decreased by 4 percent while outpatient visits have increased by 9 percent.[28] And, in 2016, outpatient services represented nearly two-thirds of rural hospitals' total gross revenue.[29]

However, the movement from inpatient care toward more outpatient services can be problematic for some hospitals, especially those with low patient volumes. Most Medicare designations and special payment programs for rural hospitals are tied to inpatient services (see Appendix for descriptions), reflecting the health care system's longstanding emphasis on acute, inpatient care. Yet, in light of low patient volume overall and the rise of outpatient care, these programs may not be sufficient to bolster the financial stability of these providers. To be sure, inpatient payment programs are necessary to support rural health care, but policymakers must also consider ways to maintain viability of outpatient care and other types of services, given the overall shift of many services out of the inpatient setting.

Coverage. Affordable health coverage is one of the most pressing financial challenges facing health care stakeholders, including consumers, providers, employers, and state and federal governments. Recent changes in coverage availability, eligibility criteria, and health plan design may reduce short-term costs for some areas of the health care system while at the same time cause negative – and often broader – unintended consequences in other areas. Individuals without adequate health insurance and those with plans that have high out-of-pocket expenses often cannot pay for emergency and other acute health services, leaving providers with higher rates of uncompensated care.

Medicaid Expansion. States that chose not to expand Medicaid coverage under the ACA, citing future costs to state budgets, have higher numbers of uninsured individuals.[30] Moreover, approximately 80 percent of rural hospital closures since 2014 have occurred in non-expansion states.[31] Although the percentage of insured individuals is not the sole factor in closures occurring across the U.S., researchers have found an association between Medicaid expansion and improved hospital financial performance, especially in rural areas.[32]

> **"The effect, in terms of the closure rates between [Medicaid] expansion and non-expansion states, seems to be especially strong for rural hospitals.**
>
> – Gregory Tung, Ph.D., Assistant Professor, Colorado School of Public Health, University of Colorado, as quoted in Healthline.com newsletter (Jan. 16, 2018)

Health Plan Design. Among the approaches employers and private health plans are taking to manage costs is to offer limited coverage plans, such as high-deductible health plans (HDHPs), so-called "skinny" plans, which cover fewer services, and short-term insurance plans. These types of health plans have grown significantly in recent years: nearly half of all non-elderly adults with private insurance are enrolled in a HDHP, and 39 percent of large employers only offer HDHPs.[33] While these plans are less expensive options for some payers, they often leave consumers with large, unexpected, costs for care, which are then shifted to hospitals in the form of uncompensated care. Evidence suggests that the uptake of HDHPs is greater in rural areas, leading to provider concerns about uncompensated care costs and inadequate patient access to services in these communities.[34]

Behavioral Health Trends. Although behavioral health concerns – including mental illness, emotional distresses and substance use disorders – have long affected the American population nationwide, recent evidence suggests that some of these conditions disproportionately affect rural communities.[35] For example, a 2017 study found that suicide rates have been consistently higher in rural areas for nearly two decades. [36] Additionally, as the entire country continues to confront the opioid crisis, rates of drug

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overdose deaths in rural communities are notably on the rise.[37] These trends are especially alarming in light of the fact that more than 60 percent of mental health HPSAs are rural or partially rural (see Figure 3).[38] Without sufficient capacity – including financial, staffing and organizational resources – to provide access to crucial services, rural hospitals will not be adequately equipped to address the unique behavioral needs of their communities.

Economic, Population and Social Changes. In recent years, economic, demographic, and social changes have deepened the challenges faced by rural communities. Numerous factors are at work, including the shift from a manufacturing-intensive economy to a more service-driven, technology-based economy. The Great Recession hit rural communities hard with higher unemployment and lagging economic growth.

> **"Many small towns have had to cut back [public] services or deliver them in combination with neighboring towns as the number of taxpayers has dwindled.**
>
> – Doug Farquhar, National Conference of State Legislatures, as quoted in pewtrusts.org, Rural Counties are Making a Comeback, Census Data Shows (March 22, 2018)

For example, access to capital for rural businesses has still not rebounded, and real estate appreciation in rural communities continues to lag behind, affecting the value of home ownership – a primary source of wealth and savings for families.[39] And between 2010 and 2014, a majority of rural counties lost businesses spanning multiple industries, including farming, manufacturing, coal, timber and fishing.[40]

> **"Fortunately, hard work, ingenuity and entrepreneurial energy can be found in every community in the country. Policymakers should focus on empowering those forces to rekindle the grassroots economic growth that made this country the world's leading economy in the first place.**
>
> – Economic Innovation Group, The 2017 Distressed Communities Index

In addition, from 2010-2016, the population in rural areas declined, due to the combination of migration (including younger workers seeking employment in urban areas) and natural changes (births minus deaths).[41,42] Social challenges as well have changed in recent years. An analysis by the Wall Street Journal found that by several measures of socio-economic well-being, rural counties fare worse than the other three major population groupings: suburbs, and medium or small metropolitan areas.[43]

Increased Regulatory Burden. According to "Regulatory Overload: Assessing the Regulatory Burden on Health Systems, Hospitals and Post-acute Care Providers," a 2017 study conducted by the AHA, the nation's hospitals, health systems and post-acute care providers spend $39 billion each year on non-clinical regulatory requirements. These costs include the staff required to meet the demands of the regulations concerning physicians, nurses, legal, management, health information technology professionals and others. CMS has acknowledged the regulatory burden on providers and continues to review the effectiveness of current regulation through its Patients over Paperwork initiative.

While rural hospitals are subject to the same regulations as other hospitals, lower patient volumes mean that, on a per-discharge basis, their cost of compliance is often higher than for larger facilities. The volume of regulation, pace of change, and complexity of the regulatory framework requires scale to

implement – and rural areas lack scale. For rural hospitals, the opportunity cost – the next best thing that could be done with the financial and human resources spent on regulatory burden – can mean the loss of local access to services.

High Cost of Prescription Drugs. Spending on pharmaceuticals has skyrocketed over the past several years. The burden of this increase falls on all purchasers, including patients and the providers who treat them. Hospitals face significant resource constraints and trade-offs as spending on drugs increases. In 2016, the AHA and the Federation of American Hospitals worked with the NORC at the University of Chicago to document hospital and health system experience with inpatient drug spending. Results showed that, while retail spending on prescription drugs increased by 10.6 percent between 2013 and 2015, hospital spending on drugs in the inpatient space rose 38.7 percent per admission during the same period.[44,45]

Emergent Challenges and Threats

In addition to managing ongoing challenges, rural hospitals also must be prepared to respond immediately to events and crises that affect the community, including those that occur unexpectedly. Capacity to address these emergent challenges – such as the opioid epidemic, violence, natural disasters and cyber attacks – represent an essential component of our nation's health and public safety infrastructure. However, this role is not explicitly funded, making it even more challenging for rural hospitals to spread scarce resources to meet the increasing challenges and needs in their communities.

> **When we heard there was a shooter inside the school, we braced for the worst. But we were prepared. We had practiced. The staff knew what their roles were and we followed our playbook.**
>
> – David L. Schreiner, President & CEO, Katherine Shaw Bethea Hospital, Dixon, Ill.

Opioid Epidemic. In 2017, more than 42,000 deaths were attributed to opioid overdoses.[46] And in 2017, the Department of Health and Human Services declared the opioid epidemic a public health emergency. Also in 2017, the Centers for Disease Control and Prevention announced that the rates of deaths from drug overdoses in rural areas were rising to surpass rates in urban areas.[47,48] According to a recent National Public Radio poll, one quarter of rural Americans say opioid and other drug abuse is the biggest issue that faces their communities.[49]

> **While no corner of the country has gone untouched by this issue, the opioid epidemic has hit rural America particularly hard.**
>
> – U.S. Department of Agriculture. Opioid Misuse in Rural America, (2018)

Congress recently passed comprehensive bipartisan legislation in response to the opioid epidemic. The Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act of 2018 comprises dozens of individual bills that direct additional federal resources toward prevention, education, coverage, treatment, workforce and law enforcement.

Hospitals have a key role in responding to the nation's opioid epidemic: from treating overdoses in the emergency department to caring for babies with neonatal abstinence syndrome to connecting patients with treatment and recovery resources.

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Violence in Communities. Incidences of violence, such as mass shootings, are events that communities hope never occur; yet hospitals must be prepared to respond. Shootings in workplaces, schools and public spaces have not been limited to any one geographic area; rather, they have occurred all across America. To prepare for incidences of mass violence, many hospitals conduct preparedness drills with local law enforcement. Conducting these drills requires hospitals to temporarily shut down non-emergency services and redirect staff to participate in preparedness activities. Federal and state agencies often provide resources to help hospitals purchase equipment to prepare for emergencies; however, the cost for lost services and staff time are borne by the hospital. Hospitals also are dealing with a wave of violence within their walls, sometimes directed at employees.[50] To keep patients and employees safe, rural hospitals are increasingly establishing partnerships with local law enforcement or hiring security, creating another necessary, but indirect cost to operating a hospital.

Human trafficking is another example of violence that is increasing in rural communities.[51,52] Victims of human trafficking will likely seek medical attention for emergency or preventive care at some point.[53] Health care professionals are on the front lines of this challenge, helping to identify and appropriately treat victims, both of which require special training.[54]

> **If a medical professional is able to identify a potential trafficking situation, he or she can connect that victim to the appropriate services that may save that victim's life.**
>
> – Polaris Project blog post, "Healthcare Professionals on the Frontline of Helping Trafficking Victims" (April 14, 2016)

Medical Surge Capacity. The ability to care for a significantly increased volume of patients when a tragic event strikes – referred to as "medical surge capacity" – is a key marker of an effective health care system.[55] For America's hospitals, such readiness is an imperative; they are always there, prepared to care in times of need. While hospitals have always had disaster plans in place, more recent incidences of hurricanes, wildfires, flooding, and threats of viruses like Ebola and Zika have raised the bar for emergency preparedness. Although rural areas are not immune to natural disasters, terrorist attacks and epidemics, these communities may not be adequately prepared for large-scale events if they lack sufficient medical staff and resources to respond to such emergencies. While federal resources, such as those authorized through the Pandemic and All-Hazard Preparedness Act, provide some support to help hospitals and communities prepare for and respond to disasters and public health emergencies, they have not kept pace with the ever-changing and growing responsibilities hospitals have in times of crisis.

Cyber Threats. Hospitals, and health care overall, remain heavily targeted by cyber adversaries. The health care field is increasingly realizing the promise of networked information technologies to improve quality and patient safety and bring efficiencies to our systems. However, with those opportunities come vulnerabilities to theft and threats to the security of personal health and payment information for patients and employees, billing records, and even the function of medical devices. Increasingly, bad actors are using phishing emails, malware, vendor access and other tactics to attempt to attack hospital computers, networks and connected devices.

Protecting information and appropriately responding to threats creates significant indirect cost for hospitals and can require individuals with specialized skills. These costs are not reimbursed by payers and can be especially difficult for rural hospitals with limited financial and human resources. This is made more challenging by the significant shortages of cybersecurity professionals across the nation.

Roadmap for Action: Updating Federal Policies and Investing in Rural Communities

In light of the persistent, recent and emergent challenges of providing care in rural areas, as well as the ongoing transformation of the health care system, federal policies need to be updated for the 21st century. New investments of resources that protect access to care also are needed to provide the tools to ensure local access to high-quality, affordable, efficient health care. Policy recommendations are identified in this section.

New Models of Care

The health care system is changing at a rapid pace, and new models of care offer alternative ways of delivering and paying for care. One important example of a new model of care is the establishment of an emergency medical center designation under the Medicare program for rural hospitals. Such a designation would allow existing facilities to meet a community's need for emergency and outpatient services without having to provide inpatient services. In addition to having emergency services provided 24 hours a day, 365 days a year, communities would have the flexibility to align additional outpatient and post-acute services with local needs, and receive enhanced reimbursement.

A New Medicare Designation for Rural Providers

- » Eligible rural hospitals that discontinue inpatient care could convert to the new designation
- » Services include 24/7 emergency and observation services, ambulance and transportation to acute facilities as needed
- » Facilities may also provide skilled nursing (separate licensed unit) and outpatient services

This type of designation has been supported in bipartisan, bicameral legislation in the 115th Congress, including the Rural Emergency Acute Care Hospital (REACH) Act (S.1130) and the Rural Emergency Medical Center Act (H.R. 5678). MedPAC also recommended the establishment of such a model in its June 2018 Report to Congress.

CMS' Center for Medicare & Medicaid Innovation (CMMI) also continues to test several new models for rural providers, including:

- The *Rural Community Hospital Demonstration,* which tests the feasibility of cost-based Medicare reimbursement for inpatient services for 30 smaller rural hospitals with 25-50 beds;
- The *Frontier Community Health Integration Project (FCHIP) Demonstration,* which tests several care delivery innovations across 10 hospitals, including cost-based reimbursement for telehealth services and certain CAH-owned ambulance services, and;
- The *Pennsylvania Rural Health Model,* which will test an all-payer global budget payment structure along with care delivery redesign for certain rural hospitals in the state.

While these demonstrations are promising, additional opportunities are needed to expand successful models and make them permanent, continue assessments of model performance, and develop new models that are flexible and meaningful for rural communities.

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As rural hospitals employ new models of care and embark on pathways to transformation, such as value-based care and population health strategies, they need flexibility and resources to be successful. **Congress and CMS should expand opportunities for rural communities to choose new models of care (e.g., establishment of an emergency medical center designation, development of new demonstrations), while ensuring flexibility in payment and delivery design.**

Reimbursement

Rural hospitals are committed to caring for their communities and improving value; however, without financial predictability, including an adequate margin for capitalization, they cannot maintain local access to essential services. For many rural hospitals, the "no margin, no mission" adage rings terribly true.

Given the persistent, recent and emergent challenges faced by rural hospitals, it is increasingly difficult to cover the high fixed costs of operating a hospital and maintain access to services while also pursuing new pathways to improve quality and value. Unfortunately, in recent years, policymakers have repeatedly cut payments to hospitals. For example, while seeking reductions to the federal budget in 2011, Congress passed Medicare sequestration, which bluntly cut all payments to hospitals and CAHs by 2 percent; these cuts have been extended several times.

Another example of recent hospital payment cuts are so-called "site-neutral" policies, which seek to reduce reimbursement for non-emergency services delivered in hospitals' off-campus provider-based departments (PBDs), including those serving rural communities. The intention of these policies is to make total payment for a service provided in a hospital the same as when a service is provided in a physician office or ambulatory surgery center. However, patient needs, cost structures and regulatory requirements vastly differ across these settings. For example, PBDs treat patients who are more likely to be Medicare or Medicaid beneficiaries, have medically complex conditions, and live in high-poverty areas. In addition, patients are commonly referred to PBDs by physicians for safety reasons, as hospitals are better equipped to handle complications and emergencies. Overall, site-neutral policies fail to recognize the reality in which hospitals operate to serve the needs of their communities.

While PBDs across the country feel the impact of these policies, rural hospitals may be especially affected in light of PBDs being frequently used as important health care access points in more remote areas. In particular, recent proposals also would reduce payments to off-campus PBDs that were previously exempt from cuts given the critical role they play in their communities. Cutting support for these facilities would clearly impede access to care for the most vulnerable patients.

Federal and private payers need to update covered services and increase reimbursements rates to cover the cost of providing care, including by opposing any further site-neutral payment policies.

Easing Regulatory Burden

Hospitals and health systems must comply with 341 mandatory regulatory requirements and an additional 288 requirements for post-acute care.[56] The AHA found that health systems, hospitals and post-acute care providers spend $39 billion each year – $7.6 million for an average-sized community hospital – on non-clinical regulatory requirements. While rural hospitals are subject to the same regulations as other

hospitals, lower patient volumes mean that, on a per-patient basis, the cost of compliance is often higher. **Policymakers should protect access to health care in rural areas by providing relief from outdated or unnecessary regulations.**

Health Information Technology (HIT). Rural hospitals are committed to improved care through use of HIT in order to meet past and current regulatory requirements. The use of electronic health records (EHRs) and other health IT to meet increased requirements for information exchange through programs like the Promoting Interoperability Program (formerly known as the EHR Incentive Programs, or meaningful use) result in significant investment to purchase, upgrade, and maintain equipment and software. Many of these costs are ongoing, including expensive system upgrades required by regulation and the recruitment and retention of trained staff to use and service the technology. Rural hospitals must meet the same regulatory requirements for the Promoting Interoperability Program as other hospitals, yet often do not need the additional technology functionality contained in required, expensive system upgrades; nor do they have the available infrastructure such as adequate broadband to support them. **While CMS recently provided needed flexibility in the Promoting Interoperability Program, concerns remain that the requirements and technology costs, particularly related to the 2015 edition certified EHR technology, are beyond the reach of some rural hospitals.**

Medicare Conditions of Participation (CoP) and Compliance. Medicare CoPs require providers to adhere to established health quality, safety and operational standards in order to participate in the Medicare program. There is tremendous value in having CoPs to ensure the safe delivery of care; however, the preparatory work, surveys and follow-up documentation required to certify that hospitals adhere to all standards presents a growing burden to providers. CoPs for Medicare are a significant source of the cost of regulatory compliance. **Surveyors assessing hospital compliance should be provided with training and guidance related to rural-specific circumstances, including low patient volume and sometimes limited capacity. In addition, future CoPs should be developed with more flexibility, a strong evidence base and alignment with other laws and industry standards.**

Direct Supervision. CMS also enforces a policy for CAHs and small (i.e., fewer than 100 beds) rural hospitals, requiring "direct supervision" for all outpatient therapeutic services (with some exceptions). This policy requires that a physician be immediately available for even the lowest risk outpatient therapeutic services, such as the application of a splint to a finger. Without adequate numbers of health professionals in rural communities to provide direct supervision, some hospitals may limit their hours of operation or reduce services due to their inability to meet this requirement. **Congress should pass a permanent moratorium on enforcement of CMS's "direct supervision" requirement for outpatient therapeutic services provided in CAHs and certain small, rural hospitals.**

96-Hour Rule. Currently, to maintain their designation, CAHs must maintain an annual length of stay (LOS) of 96 hours or less. However, in recent years, CMS enforced a condition of payment for CAHs that requires a physician to certify that a beneficiary may reasonably be expected to be discharged or transferred to another hospital within 96 hours of admission. This additional step and limitation is detrimental to CAHs, and may force them to eliminate "96-hour-plus" services, ultimately affecting access to appropriate care for Medicare beneficiaries in these facilities. **CAHs appreciate recent efforts by CMS to reduce this regulatory burden, however a statutory change is required to remove the physician certification requirement from the 96-hour rule.**

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Co-location. Hospitals often create arrangements with other hospitals or providers of care in order to offer a broader range of medical services, improve care coordination, and better meet the needs of patients – including specific patient populations. For example, a rural hospital may lease space once a month to medical specialists from out of town so that people from the community can get needed specialty care. Unfortunately, in recent years, CMS has expressed several conflicting interpretations of these rules that may differ from prior understanding, such as standards about what constitutes separateness, when separate entrances are required, which types of services may be shared, and how an adequate level of public awareness is achieved when one provider leases space to another. **CMS should clarify its rules related to shared space or "co-location" arrangements between hospitals and/or health care professionals.**

Stark Law and Anti-Kickback Statute. The Stark Law and Anti-Kickback Statute are intended to prevent fraud and abuse and govern financial arrangements between physicians and hospitals. However, they need to be updated to reflect how care is delivered today, including value-based and coordinated care. While not intended by the laws, the potential for violating these statutes may be higher for rural hospitals in light of their unique conditions. For example, limited patient volume may necessitate the need to share specialists with non-affiliated hospitals; as a result, ongoing patient referrals to these facilities could implicate the Anti-Kickback Statute. **Policymakers should remove barriers to care transformation, such as creating a "safe harbor" under the Anti-Kickback Statute and reforming the Stark Law and certain civil monetary penalties to foster and protect arrangements that promote value-based care.**

Telehealth

> **"Rural hospitals often play the role of "originating site," meaning that patients still physically go to the hospital to receive a service provided from a health professional located at a distant site. Even in cases where originating sites are eligible to bill Medicare for a telehealth facility fee, the reimbursement rates are marginal compared to the overall costs.**
>
> – American Hospital Association, 2018

Telehealth expands access to services which may not otherwise be sustained locally due to provider recruitment/retention difficulties, low patient volume, or inadequate local resources. It also holds great potential to address health care disparities, which have long existed in rural communities, including those based on geographic isolation, an aged population, and race and ethnicity. As technology has improved and people are increasingly comfortable with the delivery of care through virtual connections, the utilization of telehealth services has dramatically increased. Indeed, among rural Medicare beneficiaries, the number of telehealth visits increased from 7,015 in 2004 to 107,955 in 2013 and continues to rise.[57] Telehealth also may be especially important for providing care in specialties that are not well represented in rural areas. In a recent analysis of rural Medicare beneficiaries, researchers found that nearly 80 percent of telehealth visits were related to mental health conditions, underscoring both the need and opportunity for this type of care in rural America.[58]

Medicare has increased its coverage of telehealth services for patients living in rural areas, and in 2018,

Congress further expanded coverage to include telestroke care. However, barriers to widespread use of telehealth remain, including:

- statutory and regulatory restrictions on how Medicare covers and pays for telehealth;
- lack of adequate broadband connectivity in some areas;
- cross-state licensure hurdles for practitioners; and
- high cost of acquiring and maintaining necessary equipment.[59]

The promise of telehealth cannot be realized in rural areas without additional governmental support for these services. **Federal payers should expand coverage of services and technologies; provide payment parity with services delivered in-person; assist with the expensive start-up costs of providing access to telehealth services; and cover the cost of providing telehealth at the patient's site of care ("originating site").**

"The 25-bed [hospital]… loses Internet connections often enough that ambulance drivers are told to divert critical patients, whose CT scans are transmitted to specialists, to a hospital 50 minutes away.

– "Rural America is Stranded in the Dial-Up Age," Wall Street Journal, (June 15, 2017)

Broadband. According to the Federal Communications Commission (FCC), 34 million Americans still lack access to adequate broadband. Many of these are located in rural areas. Lack of affordable, adequate broadband infrastructure impedes routine health care operations (such as widespread use of EHRs and imaging tools) and limits their availability.[60] In August 2018, the FCC proposed the creation of a new $100 million Connect Care Pilot Program to support telehealth for low-income Americans, especially those living in rural areas. If established, the program would support the expansion of broadband and promote the use of broadband-enabled telehealth services among low-income families and veterans, with a focus on services delivered directly to patients beyond the doors of brick-and-mortar health care facilities.[61] **Federal investment in broadband connectivity should continue to be a priority.**

Prescription Drug Costs

Increased spending on prescription drugs is putting access and quality of care at risk by straining providers' ability to access the drug therapies they need to care for their patients and the ability of patients to pay for the medicines they need. The primary driver behind this growth in drug spending is higher prices, not increased utilization. Within the health care field, "pharmaceuticals" was "the fastest growing category" in terms of pricing for every month of 2016 and for most of 2017.[62] Drug manufacturers have full control over the initial price for a drug and any subsequent price increases. They are responsible for setting the price of a drug at $89,000,[63] $159,000,[64] or even $850,000[65] for a course of treatment. They also solely decide whether to increase that price by 20 percent,[66] 948.4 percent, or 1,468 percent.[67]

Actions must be taken to address the high price of prescription drugs including: fast-tracking generic medicines to market; preventing drug manufacturers from making small adjustments to older drugs and receiving financial benefits and protections reserved for new drugs; and paying generic manufacturers to delay the release of a cheaper version of the drug.[68]

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340B Program. For more than 25 years, the 340B Drug Pricing Program has been critical in expanding access to lifesaving prescription drugs and comprehensive health care services in vulnerable communities that include low-income and uninsured individuals. Congress established the 340B program in response to the pressure high-drug costs were putting on providers and with the stated objective "to stretch scarce Federal resources as far as possible, reaching more eligible patients and providing more comprehensive services."

In 2015, 340B hospitals provided $23.8 billion in uncompensated care and $51.7 billion in total benefits to their communities.[69,70] Hospitals were able to provide these benefits despite significant fiscal pressures. Also in 2015, one out of every four 340B hospitals had a negative operating margin, and one in three 340B CAHs had a negative operating margin.[71] **Any focus on limiting the 340B program as part of a plan to lower drug prices is misplaced. Efforts to scale back the program would have devastating consequences for the patients and communities served.**

Workforce

Graduate Medical Education (GME). Medicare GME funding is critical to maintain the physician workforce and sustain access to care in rural communities and across the nation. The Balanced Budget Act of 1997 (BBA) imposed caps on the number of residents for which each teaching hospital is eligible to receive GME reimbursement. The BBA also reduced over time the additional payment teaching hospitals receive for Medicare discharges, known as the indirect medical education (IME) adjustment, that reflect the higher patient care costs at these facilities. **Congress should lift the cap on the number of Medicare-funded residency slots, which would expand training opportunities in rural settings and help address health professional shortages.**

Targeted Programs. Recruitment and retention of health professionals is a persistent challenge for rural providers, resulting in workforce shortages, reduced access to care for patients and high ongoing costs to providers. Some existing programs work to ameliorate workforce deficits by incentivizing clinicians to work in rural areas, such as the Conrad State 30 and the National Health Service Corps programs, which are administered by federal agencies with funding from Congress. In addition, the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act of 2018 establishes a loan repayment program for substance use disorder treatment professionals in mental health professional shortage areas or counties hardest hit by drug overdoses. Despite the promise of these programs, with only one percent of medical residents and fellows indicating a preference for practicing in a small town or rural area, designers of rural recruitment programs will have to consider additional, unique ways to attract the next generation of clinicians.[72]

In addition, as mentioned above, advancements in telehealth can address workforce challenges by connecting patients and their providers to specialists in other locations; however, state licensure restrictions often limit the reach of telehealth services. In response, 17 states have enacted legislation supporting the Interstate Medical Licensure Compact, which expedites the licensure process for physicians wishing to practice medicine in multiple states.[73] **These recruitment and retention programs are important to support a sustainable rural health care workforce; however, additional solutions need to be developed to address workforce shortages and challenges in rural areas.**

Conclusion

Although rural hospitals have long faced unique circumstances that can complicate health improvement efforts, more recent and emergent challenges are exacerbating their financial instability – and by extension, the economic health of their communities. Individually, these are complex, multifaceted challenges. Taken together, they are immense, requiring policymakers, stakeholders and communities to work together, innovate and embrace value-based approaches to improving health in rural communities.

The federal government must play a principal role by updating policies and investing new resources in rural communities. A complete listing of AHA policy priorities and recommendations for America's rural hospitals and communities is available in the 2019 Rural Advocacy Agenda, 2019 Advocacy Agenda and the Task Force on Ensuring Access in Vulnerable Communities Report; all are available at *www.aha.org*.

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Appendix

Figure 5: Medicare Designations for Rural Hospitals

Designation	Eligibility Criteria	Medicare Payment
Critical Access Hospital (CAH)	• Rural or acquires rural status (42 CFR 412.103 for detail) • More than 35 miles from nearest hospital or CAH or more than 15 miles in areas with hazardous terrain or only secondary roads or designated by state as "necessary provider" before 2006 • 25 beds or fewer (including swing beds) • 24-hour emergency services • Annual average length of stay of 96 hours or less per patient for acute care	• 101 percent of "reasonable costs" for both inpatient and outpatient care. CAHs are not subject to inpatient prospective payment system (PPS) or outpatient (PPS) and are not "subsection (d)" hospital • 101 percent of reasonable costs for swing bed services
Sole Community Hospital (SCH)	More than 35 miles from other "like" hospitals (excludes CAHs) or rural and one of the following: • Between 25 and 35 miles from other like hospitals and serves as main hospital in the vicinity (42 CFR 412.92 for detail) • Between 15 and 25 miles, but other hospitals often inaccessible (e.g., due to severe weather) • Nearest like hospital is at least 45 minutes away	• **Inpatient:** Higher of standard inpatient PPS or hospital-specific rate (HSR) • HSR derived from cost per discharge in a base year (1982, 1987, 1996, 2006), adjusted for inflation and case mix • **Outpatient:** Outpatient PPS + 7.1 percent (except drugs and biologics)
Medicare Dependent Hospital (MDH)	• Rural or acquires rural status (42 CFR 412.103 for detail). Expired in 2017 but extended through 2022 • Not a SCH • 100 beds or fewer • At least 60 percent of inpatient days or discharges are Medicare Part A beneficiaries (42 CFR 412.108 for detail)	• **Inpatient:** Standard IPPS + 75 percent of amount by which highest HSR exceeds PPS • HSR derived from cost per discharge in base year (1982, 1987, 2002), adjusted for inflation and case mix • **Outpatient:** Standard outpatient PPS
Rural Referral Center (RRC)	Rural plus one of the following (42 CFR 412.96): • 275 beds or more, or • Most Medicare patients referred by outside providers AND most (services provided to) Medicare patients live 25+ miles away, or • High case-mix + high discharge volume + one of the following: mostly specialty practitioners, most inpatients live 25 miles away, many patients referred by outside providers	• **Inpatient:** Standard inpatient PPS; special treatment for Medicare DSH and geographic reclassification • **Outpatient:** Standard outpatient PPS; receive inpatient reclassified wage index
Rural Community Hospital (RCH)	Demonstration model; extended in 2016 for 5 years (30 participating hospitals) • Rural • Fewer than 51 acute care beds • 24-hour emergency services • Not designated/ eligible to be CAH	• **Inpatient:** 100 percent of reasonable costs (first year). Lesser of reasonable costs and target amount (subsequent year) • **Outpatient:** Standard outpatient PPS

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Medicare Designations for Rural Hospitals (Continued)

Program	Eligibility Criteria	Medicare Payment
Low-volume Adjustment (LVA)	Expired in 2017 but extended through 2022 with new criteria beginning in 2019: • Fewer than 3,800 total discharges • Located more than 15 road miles from the nearest subsection (d) hospital	• **Inpatient:** Sliding scale add-on: 25 percent for hospitals ≤ 500 total discharges to 0 percent for hospitals ≥ 3,800 total discharges • **Outpatient:** Standard outpatient PPS
Ambulance Add-on Adjustment	• Rural and "super" rural areas (lowest 25 percent in terms of population density)	• 3 percent add-on to the ambulance fee schedule rate payment for trips originating in rural areas or rural census tracts of urban areas • 22.6 percent increase in the base rate of the fee schedule for ground services originating in "super" rural areas

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Chicago Office:
155 N. Wacker Drive, Suite 400
Chicago, IL 60606
312.422.3000

Washington Office:
800 10th Street, NW
Two CityCenter, Suite 400
Washington, DC 20001
202.638.1100

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