TAHOE FOREST HOSPITAL DISTRICT

2020-05-14 Board Quality Committee Meeting

Thursday, May 14, 2020 at 9:00 a.m.

Pursuant to Section 3 of Executive Order N-29-20, issued by Governor Newsom on March 17, 2020, the Board Quality Committee meeting for May 14, 2020 will be conducted telephonically through Zoom.

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

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

If you would like to speak on an agenda item, you can access the meeting remotely: Please use this web link: https://tfhd.zoom.us/j/92670137583

If you prefer to use your phone, you may call in using this number: (346) 248 7799 or (301) 715 8592, Meeting ID: 926 7013 7583

Meeting Book - 2020-05-14 Board Quality Committee Meeting

TAHOE FOREST HOSPITAL DISTRICT

QUALITY COMMITTEE
AGENDA

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

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

1. CALL TO ORDER

2. ROLL CALL
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: 01/22/2020 ..... ATTACHMENT

6. ITEMS FOR COMMITTEE DISCUSSION AND/OR RECOMMENDATION

6.1. Safety First

6.2. Patient & Family Centered Care

6.2.1. Patient Experience Presentation
Patient will share their experience with Tahoe Forest Health System.

6.2.2. 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. Healthcare Facilities Accreditation Program (HFAP)
Quality Committee will receive a status report of the HFAP accreditation survey process.

6.5. Quality Assurance/Process Improvement Plan (QA/PI) .....ATTACHMENT
Quality Committee will review the QA/PI 2020 Priorities and discuss other key indicators and educational opportunities for the upcoming year.

6.6. Board Quality Education

6.6.1. American Hospital Association (AHA) Report on Rural Communities .....ATTACHMENT
Committee will discuss the following educational article: *BoardBrief: Navigating the Challenges of COVID-19*. governWell. Retrieved on April 21, 2020 at: https://www.team-iha.org/files/non-gated/quality/boardbrief-navigating-the-challenges-covid-19.aspx

7. REVIEW FOLLOW UP ITEMS / BOARD MEETING RECOMMENDATIONS

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

9. ADJOURN

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

Note: It is the policy of Tahoe Forest Hospital District to not discriminate in admissions, provisions of services, hiring, training and employment practices on the basis of color, national origin, sex, religion, age or disability including AIDS and related conditions. Equal Opportunity Employer. The telephonic meeting location is accessible to people with disabilities. Every reasonable effort will be made to accommodate participation of the disabled in all of the District's public meetings. If particular accommodations for the disabled are needed or a reasonable modification of the teleconference procedures are necessary (i.e., disability-related aids or other services), please contact the Executive Assistant at 582-3481 at least 24 hours in advance of the meeting.

TAHOE FOREST HOSPITAL DISTRICT

QUALITY COMMITTEE
DRAFT MINUTES

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

1. CALL TO ORDER
Meeting was called to order at 12:10 p.m.

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

Staff in attendance: Harry Weis, Chief Executive Officer; Judy Newland, Chief Operating Officer; Karen Baffone, Chief Nursing Officer; Dr. Shawni Coll, Chief Medical Officer; Dr. Peter Taylor, Medical Director of Quality; Dorothy Piper, Director of Medical Staff Services; Lorna Tirman, Patient Experience Specialist; Pati Johnson, Patient Family Advisory Council member; 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: 11/14/2019
Director Brown moved to approve the Quality Committee minutes of November 14, 2019, seconded by Director Wong.

6. ITEMS FOR COMMITTEE DISCUSSION AND/OR RECOMMENDATION

6.1. Safety First
CMO shared safety first about proctoring and privileging for new physicians coming on staff (i.e. TTMG).

6.2. Patient & Family Centered Care

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

Jim Sturtevant, Administrative Director of Transitions, presented to the PFAC last night on Home Health, Hospice, and Palliative Care.

Director Wong noted the PFAC was working to increase return of surveys. Patient Experience Specialist shared, on average, the District is aligned with the national average. Each service line has a different response rate.

Quality Committee would like to see percentage of response rates included in future reports.

The committee would also like Patient Experience Specialist to ask a high performing provider if they are scripting.

6.3. Patient Safety

6.3.1. BETA HEART Program Progress Report

Quality Committee received a progress report regarding the BETA HEART program.

Quality scheduled Deanna Tarnow of BETA to come in February to survey two metrics.

There was an overwhelming interest from staff interested in the Peer Support Group for Care for the Caregiver.

Dawn Colvin, Patient Safety Officer, will share more at the board meeting tomorrow night.

The District has previously sent 31 staff members to the BETA conference. There will be a new group attending the BETA conference this year.

Director of Quality anticipates meeting the deadlines.

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

Quality Committee received a summary report of the QA/PI 2019 Priorities and discussed recommendations for 2020 priorities.

The Board of Directors will approve the policy at the February board meeting.

Minimal changes have been made. “Just Culture” terminology has been updated to “high reliability”. Ongoing survey readiness and compliance was added as a priority identified.

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)*.

The GQA tool was scored by Administration as well as Director Wong.

Director Brown commented she is not sure what else can be done with the tool beyond reviewing it a few times a year and sees different possibilities for board education.

Committee discussed the scoring for Category 4, number 3 and 5 on diversity on page 39 of the packet. Truckee is not a diverse community but there are disparities in care. CMO suggested Human Resources report specifically on diversity.

CEO stated the District is well below the state average for charges. He will circle back on data around cost per discharge.

The District scores high using the tool. Director Wong commended the quality department for their work.

Committee agreed to do an update later in the year to see where the organization is at.

6.6. Healthcare Facilities Accreditation Program (HFAP)

Director of Quality provided an overview of the HFAP survey process.

The District have been using HFAP for the last 20 years. The six-month window opened on January 4, 2020.

The District completes routine survey preparation year round. Life safety will be a big focus of the surveys and disaster preparation.

HFAP uses 17 chapters for their accreditation survey.

Quality Committee reviewed licensing details presented on page 63 of the packet. CMS utilizes CDPH to survey the Extended Care Center and Home Health. Truckee Surgery Center operates on a separate license from Tahoe Forest Hospital.

6.7. Board Quality Education

6.7.1. American Hospital Association (AHA) Report on Rural Communities

Committee discussed the following AHA report: *Rural Report: Challenges Facing Rural Communities and the Roadmap to Ensure Local Access to High-quality, Affordable Care* (2019).

Quality Committee felt it was a great article and our organization is positioning itself well.

Director Wong noted the organization needs to be present at state level. CEO noted the regulatory burden is enormous. The District is very active at the California and Nevada state level.

Discussion was held about nurse staffing ratios. The state no longer allows a nursing supervisor to be the triage nurse at night. California requires us to pay for a third nurse at night even though our volumes do not warrant it. A non-union employee cannot cover breaks.

CMO said there will be some coding requirements that will be rolling out in January 2021. Education will be rolled out which will prepare for these changes.

7. REVIEW FOLLOW UP ITEMS / BOARD MEETING RECOMMENDATIONS

-Follow up on quiet packs
-myChart update

8. NEXT MEETING DATE

The next committee meeting will be held on May 14, 2020.

9. ADJOURN

Meeting adjourned at 1:20 p.m.

Patient and Family Advisory Council (PFAC) Summary Report

November 2019 to May 2020

Submitted by: Lorna Tirman, RN, PhD

Patient Experience Specialist

- Some members have shown an interest in serving in other areas of the hospital in addition to the monthly PFAC meetings. Kevin Ward volunteers in the Quality Department tracking our service recovery toolkits. Pati Johnson serves on our Board Quality Committee which meets quarterly.

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

- Plan for 2020 is to continue to review patient feedback and comments from patient experience surveys, help improve quality, safety, and patient experiences.

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

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

- January meeting: Jim Sturtevant gave an update on our Home Health, Hospice and Palliative Care services, including how our two thrift stores contribute to these programs.

- February Meeting: Dawn Colvin, Safety Officer, presented on our current Beta Heart program, transparency and disclosure programs and also discussed our Peer Support Team and what they do for our staff and providers. Dawn invited members of the PFAC to interview for our Peer Support Team if they are interested.

- March meeting cancelled due to onset of Covid-19 and limiting of gatherings and meetings.

- April 21 was a virtual meeting: Harry Weis gave an update to current hospital operations as well as answer questions from the committee.

- Plan to send at least one PFAC member to annual Patient and Family Centered Care meeting in Los Angeles which has been moved to September 2020.

- We have one new member on the PFAC since our last report. We currently have 11 community members serving on our PFAC. We continue to seek and recruit new members to represent our community on our PFAC.
- The Tahoe Forest Hospital Patient and Family Advisory Council meets every month, 9 months in the year. We do not meet July, August, or December.
- Next PFAC Meeting is May 19, 2020.

Current members:

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

Beta HEART Progress Report for Year 2020 (updated April 15, 2020)

*Beginning in 2020, Beta HealthGroup changed their annual Incentive process to be "Annual", meaning that each year the 5 domains would have to be re-validated to be eligible for the incentive credit.

General Updates for 2020:

- Due to the COVID-19 outbreak in Feb/March, all Beta HEART validations have been put on hold for 2020
- Beta HEART conferences in May (and possibly September) will be held virtually vs. in person.
- SCORE Survey for 2020 (year 3 for TFHD) was cancelled.

Domain	History of Incentive Credits (2% annually)	Readiness for Validation	Comments
Culture of Safety: A process for measuring safety culture and staff engagement	2019: $13,101	N/A for 2020	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 has conducted debriefings and worked with leadership team/all departments to set Year 2 goals
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	2019: not validated	N/A for 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	2019: not validated	N/A for 2020	Many components in place. Revised disclosure checklist to reflect best practices. Quality team will take the lead on most major disclosures. October 23, 2019 communication training attended by over 30 people and was well received. Developed guidelines for leadership to perform internal/small issue disclosures (see attached).
Care for the Caregiver: An organizational program that ensures support for caregivers involved in an adverse event	2019: not validated	N/A for 2020	Lauren Caprio (HR) and Stephen Hicks (Educator) are co-chairing Peer Support. Policy, Peer Support team (some with formal training), process, education, Name/Logo all have been completed. Resilience Rounds occurring during COVID19 outbreak. Ongoing education in Pacesetter and via emails. Collaboration with Northern Nevada Peer Support Network NNPSN (1st responder network) and developing lists of resources
Early Resolution: A process for early resolution when harm is deemed the result of inappropriate care or medical error	2019: not validated	N/A for 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 Dashboard process is being finalized.

TAHOE FOREST HEALTH SYSTEM

Origination Date:	*09/1996*
Last Approved:	*03/2020*
Last Revised:	*03/2020*
Next Review:	*03/2021*
Department:	*Quality Assurance / Performance Improvement - AQPI*
Applicabilities:	*System, Truckee Surgery Center*

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.

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
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^{TM}), supporting Triple Aim, and ensures compliance with regulatory, statutory, and contractual requirements.

Board Quality Committee

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

Medical Executive Committee

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

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

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

Department Chairs of the Medical Staff

A. The Department Chairs:

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

Medical Staff

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

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

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

Hospital Management (Directors, Managers, and Supervisors)

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

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

Adverse Event/Error or Unanticipated Outcome and implement changes to reduce the probability of such events in the future.

Employees

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

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

C. Employees are expected to do the following:

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

PERFORMANCE IMPROVEMENT STRUCTURE

Medical Staff Quality Assessment Committee

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

The Medical Staff Quality Assessment Committee:

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

B. Regularly reviews progress to the aforementioned plans.

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

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

E. Elicits and clarifies suspected or identified problems in the provision of service, quality, or safety

standards that may require further investigation;

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

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

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

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

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

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

Performance Improvement Committee (PIC)

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

B. The Performance Improvement Committee will:

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

SCIENTIFIC METHOD FOR IMPROVEMENT ACTIVITIES

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

Performance Improvement Teams

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

volume.

B. Performance Improvement Teams will:

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

PERFORMANCE IMPROVEMENT EDUCATION

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

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

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

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

PERFORMANCE IMPROVEMENT PRIORITIES

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

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

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

C. Because Tahoe Forest Health System is sensitive to the ever changing needs of the organization,

priorities may be changed or re-prioritized due to:

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

DESIGNING NEW AND MODIFIED PROCESSES/ FUNCTIONS/SERVICES

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

1. Key individuals, who will own the process when it is completed, are assigned to a team led by the responsible individual.
2. An external consultant is utilized to provide technical support, when needed.
3. The design team develops or modifies the process utilizing information from the following concepts:
    a. It is consistent with our mission, vision, values, and strategic priorities and meets the needs of individual served, staff and others
    b. It is clinically sound and current
    c. Current knowledge when available and relevant, i.e., practice guidelines, successful practices, information from relevant literature and clinical standards
    d. It is consistent with sound business practices
    e. It incorporates available information and/or literature from within the organization and from other organizations about potential risks to patients, including the occurrence of sentinel/near-miss events, in order to minimize risks to patients affected by the new or redesigned process, function, or service
    f. Conducts an analysis, and/or pilot testing, to determine whether the proposed design/redesign is an improvement and implements performance improvement activities, based on this pilot
    g. It incorporates the results of performance improvement activities
    h. It incorporates consideration of staffing effectiveness
    i. It incorporates consideration of patient safety issues
    j. It incorporates consideration of patient flow issues
4. Performance expectations are established, measured, and monitored. These measures may be developed internally or may be selected from an external system or source. The measures are selected utilizing the following criteria:
    a. They can identify the events it is intended to identify

b. They have a documented numerator and denominator or description of the population to which it is applicable

c. They have defined data elements and allowable values

d. They can detect changes in performance over time

e. They allow for comparison over time within the organization and between other entities

f. The data to be collected is available

g. Results can be reported in a way that is useful to the organization and other interested stakeholders

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

PROACTIVE RISK ASSESSMENTS

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

1. A Failure Mode and Effect Analysis (FMEA) will be completed based on the organization's assessment and current trends in the health care industry, and as approved by PIC or the MS QAC.
2. The Medical Staff Quality Committee and other leadership committees will recommend the processes chosen for our proactive risk assessments based on literature, errors and near miss events, sentinel event alerts, and the National Quality Forum (NQF) Endorsed Set of Safe Practices.

a. The process is assessed to identify steps that may cause undesirable variations, or “failure modes”.

b. For each identified failure mode, the possible effects, including the seriousness of the effects on the patient are identified and the potential breakdowns for failures will be prioritized.

c. Potential risk points in the process will be closely analyzed, including decision points and patient’s moving from one level of care to another through the continuum of care.

d. For the effects on the patient that are determined to be “critical”, an event analysis/root cause analysis is conducted to determine why the effect may occur.

e. The process will then be redesigned to reduce the risk of these failure modes occurring or to protect the patient from the effects of the failure modes.

f. The redesigned process will be tested and then implemented. Performance measurements will be developed to measure the effectiveness of the new process.

g. Strategies for maintaining the effectiveness of the redesigned process over time will be implemented.

3. Ongoing hazard surveillance rounds, including Environment of Care Rounds and departmental safety hazard inspections, are conducted to identify any trends and to provide a comprehensive ongoing surveillance program.
4. The Environment of Care Safety Officer and EOC/Safety Committee review trends and incidents related to the Safety Management Plans. The EOC Safety Committee provides guidance to all departments regarding safety issues.

5. The Infection Preventionist and Environment of Care Safety Officer, or designee, complete a written infection control and pre-construction risk assessment for interim life safety for new construction or renovation projects.

DATA COLLECTION

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

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

REPORTING

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

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

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

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

E. Tahoe Forest Health System also recognizes the importance of collaborating with state agencies to improve patient outcomes and reduce risks to patients by participating in quality reporting initiatives (See Attachment E for External Reporting listing).

CONFIDENTIALITY AND CONFLICT OF INTEREST

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

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

ANNUAL ASSESSMENT

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

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

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

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

PLAN APPROVAL

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

Related Policies/Forms:

Medication Error Reduction Plan, APH-34

Medication Error Reporting, APH-24

Infection Control Plan, AIPC-64

Environment of Care Management Program, AEOC-908

Utilization Review Plan (UR), DCM-1701

Risk Management Plan , AQPI-04

Patient Safety Plan, AQPI-02

Emergency Operations Plan (Comprehensive), AEOC-17

Discharge Planning, ANS-238

Trauma Performance Improvement Plan

References:

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

All revision dates: 03/2020, 03/2020, 11/2019, 05/2019, 03/2019, 03/2018, 02/2017, 02/2017, 02/2016, 12/2014, 02/2014

Attachments

A. Quality Initiatives 2020.docx
B. CAH Services by Agreement 2020
C. QA PI Reporting Measures 2020
D. QI Indicator Definitions 2020
E. External Reporting 2020

Approval Signatures

Step Description	Approver	Date
	Janet VanGelder: Director	03/2020
	Janet VanGelder: Director	03/2020

BoardBrief

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Knowledge Resources for Governing Effectiveness

Navigating the Challenges of COVID-19

Hospital and health system leaders are working diligently to prepare for and respond to COVID-19. What are the critical issues for boards of trustees to consider? What information does the board absolutely need to know? This briefing highlights these important questions and areas for board consideration in a practical seven-point framework.

The coronavirus pandemic (COVID-19) is placing unprecedented demands on the U.S. health system. As a "novel" or new virus, the coronavirus that causes COVID-19 is by its very nature unpredictable. Because it is new, there is no immunity to it yet, nor is a vaccine currently available. Therapies to treat victims are largely untested. Hospitals and their associated continuum of services – such as ambulatory care, long term care, home health care, laboratory and diagnostic services, and telemedicine – are crucial components of community response to the pandemic. The sheer rapidity at which the pandemic has grown requires that every community, hospital and health system across the country be as prepared as possible to receive and care for patients with COVID-19.

Seven areas for board consideration include:

#1: Ensure that an Effective Emergency Preparedness Plan is in Place

#2: Ensure Effective Infection Identification, Management and Prevention

#3: Ensure that an Effective Crisis Communication Plan is in Place

#4: Ensure a Safe, Healthy and Sufficiently Trained Workforce

#5: Ensure Ethical Management of Scarce Resources

#6: Understand the Financial Implications and the Hospital Leadership's Response

#7: The "Look Back": Evaluate the Hospital's Emergency Response, then Recalibrate

The board, along with senior management, sets the overall organizational tone in addressing this pandemic. Leadership must strike a balance between an optimistic, and yet realistic, message to all the key stakeholders, including the community at large. Board members can have a profound impact at this critical time by being calm, positive, appreciative, and supportive of the work being carried out by their organizations. A statement from the board chair on behalf of the board, perhaps signed by all the board members, reflecting both confidence in the hospital or health system leadership as well as assurances that the board has taken the necessary steps outlined in this briefing, will send a strong message to all stakeholders.

Hospital and health system boards have the fiduciary responsibility to ensure that emergency preparedness plans, policies, procedures, processes, resources, agreements, training, and staffing are in place to effectively respond to this extraordinary local, national and global crisis.

#1: Ensure that an Effective Emergency Preparedness Plan is in Place

The board's initial role is to ensure that an emergency preparedness plan is in place and fully funded. The board's role is high-level, focused on policy, strategy, and ensuring appropriate resources, while hospital management determines the details and ensures effective execution. Hospital management and staff are responsible for ordering the equipment, supplies, facility design, written agreements (such as for transportation or patient transfers) and human resources necessary to carry out the plan. The board ensures sufficient funding. In addition, the board may well be asked to help raise outside funds for specific emergency preparedness projects, leveraging their connections within the community.

Hospital management is responsible for arranging and coordinating drills and community-wide disaster simulations to test the emergency preparedness and response plan. The board is responsible for ensuring all of this happens. Board members may be asked to participate in the drill or simulation, discussing the outcomes, as well as assessing and scoring the hospital's response and that of other participating community organizations.

#2: Ensure Effective Infection Identification, Management and Prevention

What is unique about the health care system's emergency response to the current COVID-19 pandemic – unlike emergency responses to natural disasters or mass casualties − is that it requires all hospitals to ensure their staffs are trained, equipped, and capable of practices needed to promptly:

- Identify, isolate, and provide care for suspected or confirmed COVID-19 patients;
- Monitor and manage any staff and visitors who may be exposed to the coronavirus;
- Prevent the spread of the disease within the facility; and
- Communicate effectively within the hospital, with authorities and with the public.

The U.S. Centers for Disease Control and Prevention's *Coronavirus Disease 2019 (COVID-19) Hospital Preparedness Assessment Tool* identifies the ten most important areas for hospitals to carefully assess in preparation for potential arrivals of COVID-19 patients. A detailed self-assessment checklist is available online from the CDC's website.

CDC COVID-19 Hospital Preparedness Assessment: Ten Key Elements

- Infection prevention and control policies and training for healthcare personnel;
- Process for rapidly identifying and isolating patients with confirmed or suspected COVID-19;
- Patient placement;
- Transmission-Based Precautions (use Standard, Contact, Airborne Precautions plus eye protection for patients with confirmed or suspected COVID-19 cases);
- Movement of patients with confirmed or suspected COVID-19 within the facility;
- Hand hygiene;
- Environmental cleaning;
- Monitoring and managing healthcare personnel;
- Visitor access and movement within the facility;
- Facility regularly monitors the situation on CDC's coronavirus disease (COVID-19) web page.

Download the CDC checklist

#3: Ensure that an Effective Crisis Communication Plan is in Place

In addition to including a communications component in the hospital's emergency preparedness plan, the hospital should be part of a shared community-wide crisis communication plan. Having a plan in place that links all the key players together ensures that critical minutes aren't wasted, or worse, that inaccurate information is shared with board members, patients, families, staff, the public, community partners, and authorities.

Hospital management should have in place a clear process for regular communications updates to the board. The hospital should consider using its website, as well as social media vehicles and local news media, to communicate important updates to the public. The updates should

include how to access services such as ambulatory care and outpatient pharmacy services, or cancellations of elective surgeries during the pandemic.

Rumors in a community can abound and result in unnecessary panic and missteps. In order for the community to have trust in the hospital, its leaders and personnel, it's critical that the hospital communicate accurately, calmly, and with transparency, while still respecting patient privacy concerns. Board members will be asked questions by the public or by local news media; however, there should be ***one*** designated hospital communications spokesperson or small team in place to consistently communicate the hospital's message. Board members should refer any questions to the identified process or person − and not improvise responses to inquiries they receive.

#4: Ensure a Safe, Healthy and Sufficiently Trained Workforce

In order to effectively respond to the extraordinary demands created by COVID-19, a top priority of hospitals is to maintain a trained and healthy workforce in sufficient numbers to respond to the needs of suspected or confirmed patients that the hospital receives. Ensuring that the hospital is able to provide adequate Personal Protective Equipment (PPE) such as masks, gloves, and gowns is absolutely essential for the protection of all staff who come in contact with COVID-19 patients. Urgent concerns about the availability of PPE are already being expressed by hospital leaders and health care personnel in communities where the incidence is high and growing.

Hospital personnel who develop respiratory symptoms such as cough or shortness of breath should be instructed ***not*** to report to work. The board should ensure that the hospital's sick leave policies are flexible and consistent with public health guidance – and that hospital employees have been made aware of these policies. Hospital management should ensure that the hospital's personnel policies, including for those reporting as sick and for sick leave, are implemented and are strictly adhered to across all departments.

Hospitals should be prepared to bring in additional health care personnel as needed to manage COVID-19 "surges." Physician credentialing is a board responsibility, so having an emergency credentialing plan makes sense. For example, there should be a policy for bringing in physicians who practice at other local hospitals. While these additional resources may be necessary and crucial as part of the pandemic response, board members and hospital leaders must also ensure that the quality of care provided by the additional caregivers meets the organization's quality standards.

The far-reaching implications of the pandemic response – including community "shelter in place" orders, closures of schools and businesses, and in some cases, loss of employment, has added to the stress that healthcare personnel now face. In order to support its workforce, the hospital may need to institute new personnel practices for the duration of the pandemic

response. These practices may include helping employees with basic needs so that they can report for work. Examples may include:

- Provision of temporary living accommodations for some staff and possibly, their families and even pets;
- Designated "time out" or sleep rooms for staff who are working long hours or extra shifts;
- Advance or cash payments on paychecks if banks are closed;
- On-site (on the hospital campus) or in-home well child care for the children of essential employees by using screened and trained volunteers;
- Possible in-home care or support for elderly or disabled family members of staff who are considered essential;
- Medical daycare or in-home care for sick family members
- Augmenting clinical staff with nontraditional hospital personnel to assist with non-clinical activities; and
- Additional psychological, emotional, and spiritual support for staff involved with caring for COVID-19 patients.

#5: Ensure Ethical Management of Scarce Resources

While it is the role of hospital management to determine the day-to-day allocation of resources that may become scarce, the board has the important responsibility to ensure that management has carefully considered and made plans for this potential. For example, in managing its workforce and availability of emergency resources, have hospital leaders considered the feasibility of instituting more telehealth approaches?

Shifting practices to triaging and assessing ill patients remotely using nurse advice lines, provider "visits" by telephone, text monitoring system, video conference, or other telehealth and telemedicine methods can reduce exposure of ill persons to staff and minimize surge on facilities. Many clinics and medical offices already use these methods to triage and manage patients after hours as part of usual practices. Managing persons at home who are ill with mild disease can reduce the strain on healthcare systems — however, these patients will need careful triage and continuous monitoring.

Accepting an influx of patients with COVID-19 will likely require the hospital to prioritize the care to *other* patients – such as those previously scheduled for procedures or elective surgeries – including which services and types of procedures can be deferred, for how long, and with

what consequences. The hospital will need to create an alternative plan for patients who will be deferred, one that should be monitored and refined based on lived experience.

In a severe pandemic, not all patients in need of intensive care will be able to be accommodated in the ICU. Normal staffing ratios and standard operating procedures will not be able to be maintained. The hospital may need to plan for alternative sites to provide ICU-like care within the hospital, such as the catheterization lab, catheterization recovery, operating rooms, the post-anesthesia care unit, or the endoscopy unit. Changes in hospital policy and procedures should be implemented by an active decision of the hospital leadership in consultation with the medical staff and civil authorities.

One of the most challenging demands that many hospitals will inevitably face is determining objective criteria and clinical guidelines for making decisions regarding the triage and management of COVID-19 patients who may be competing for scarce resources such as hospital admission, ventilators, equipment, medications, and intensive care resources. These critical, ethical and legal decisions should not be made by one person or even just a few people. The criteria used to make these decisions should be created in advance, formally adopted by the medical staff and hospital leadership, and approved by the board. Many hospitals will want to call upon existing structures, processes, or committees that typically address ethical considerations and policies, to help determine and propose these decision-making criteria.

#6: Understand the Financial Implications and the Hospital Leadership's Response

Hospitals are experiencing an immediate threat to their financial resources as a result of the coronavirus pandemic. Additionally, financial experts are increasingly predicting a prolonged recession as a result of the COVID-19's impact on economies worldwide. Even with regulatory action, the crisis is likely to threaten the short, medium, and long-term financial sustainability of hospitals, many of which already faced near-record-low operating margins before coronavirus emerged.

Boards need to understand the financial implications and how hospital leadership is addressing the challenges. Whether related to the short-term impact of canceling procedures and elective surgeries, the increased costs associated with obtaining crucial supplies, or longer-term economic issues, hospitals will likely face fiscal impacts. Anticipated hospital revenues may be considerably less, necessitating a review of both strategic and operational plans as well as the annual budget. Board members may be asked to get involved in identifying and making connections with funding sources such as foundations, grants, individual and corporate donors.

During times of crisis and economic insecurity, it is particularly important for hospital governing boards to keep the public trust. In the oversight of hospital finances, governing boards can and must be held accountable to the people of the communities they serve. Especially during a crisis, trust is an asset no board can do without.

Financial and strategic planning questions to consider include:

- What is the strategy for navigating financial changes due to COVID-19 and an economic downturn?
- What measures are being taken to stabilize revenue shortfalls and expense growth?
- Will the hospital need to secure additional short-term funding in order to sustain operations?
- Is the board confident in the hospital's business continuity plan?
- What are the longer-term financial risks?
- What are the implications and opportunities for philanthropy?
- How should the board gauge the hospital's financial performance over the next 12 – 18 months?
- What additional strategic planning needs to be undertaken to address the financial implications of COVID-19?
- Does the board have an adequate financial understanding to review financial impacts, trends, and the potential need for changes in the hospital's strategic course?

#7: The "Look Back": Evaluate the Hospital's Emergency Response, then Recalibrate

The governing board's role in a pandemic or any disaster does not end once the immediate event has ended. When life is returning to normal, the board should be involved in thoroughly assessing the hospital's response to the COVID-19 pandemic. As with any crisis, some things will have gone according to plan. Some will not. The board needs to know the "lessons learned" as well as potential opportunities for improvement as part of the hospital's future emergency preparedness planning. The board should work with hospital leadership to weigh what, if any, additional resources are needed to aid the hospital as it updates and upgrades its future emergency preparedness plan. The board may then identify and implement mechanisms to adequately fund these necessities.

Summary

In summary, COVID-19 will undoubtedly be the most serious test of our hospitals in many decades – as well as the preparedness of our overall health system to respond to a crisis of unprecedented proportions effectively. Hospital and health system boards play a critical role in assuring that policies, processes, structures, communications, and resources are in place and ready to meet this great challenge.

As hospitals and health system leaders respond to the challenges of COVID-19, sharing with colleagues, the lessons learned and effective board practices is important. Please send your thoughts, insights and questions directly to *Barbara Lorsbach, President, governWell™, blorsbach@governwell.net.*

The information and insights that are shared will be used to help leadership teams and governing boards stay up to date on the latest COVID-19 governance issues and practices.

Additional Resources:

COVID-19 Websites:

The Centers for Disease Control and Prevention - COVID-19

The World Health Organization - COVID-19

American Hospital Association COVID-19 Web page

Centers for Medicare and Medicaid Services - CMS COVID-19

Johns Hopkins University Coronavirus Resource Center

Refer to you state hospital association as well as state and local government for additional resources.

COVID-19 Hospital Resources:

CMS Adult Elective Surgery and Procedures Recommendations - CMS

COVID-19 Healthcare Planning Checklist - US Department of Health and Human Services

Hospital Preparedness Checklist - Centers for Disease Control and Prevention (CDC)

Pandemic Preparedness for Healthcare Workers– Occupational Safety and Health Administration

Coronavirus Scenario Planning - Advisory Board

COVID-19 Related Cybersecurity Information - American Hospital Association

COVID-19 Long-term Care Facilities and Nursing Homes Resource:

Preparing for COVID-19: Long-term Care and Nursing Homes - CDC

Ethical Preparedness Resources:

Ethical Preparedness for Pandemic Influenza: A Toolkit - Makkula Center for Applied Ethics, Santa Clara University

Resources used for research and context purposes have been sourced as accurately as possible at the time of publication. If you believe something has been cited incorrectly, please contact governWell™ at contact@governwell.net.

About the Authors

Anne Rooney, RN, MS, MPH, *President, Anne Rooney & Associates, Inc.* Anne Rooney brings 30+ years experience in global accreditation and standards development, health care quality strategy, process improvement, and patient safety consulting, education, and management through The Joint Commission, as well as in several senior consulting roles both in the U.S. and internationally. Anne currently has her own global healthcare consulting practice with special focus and expertise in health system strengthening, health policy, strategic and business planning, accreditation and quality systems development, clinical quality and patient safety, and process improvement. She has experience in serving in the governance of various non-profit organizations in various roles including Board President, Secretary, Chair of Human Resources and Compensation Committee and Chair of the Development Committee. Anne has extensive international experience with Ministries of Health, government agencies, and health care provider organizations in the U.S., Europe, Africa, the Middle East, and Asia. Anne has published numerous articles, given many professional presentations, and is a strong leader with the ability to work effectively with healthcare providers, government officials, Boards of Directors, and health care professionals in diverse cultures and environments around the world.

Mary Rooney Sheahen, RN, MS, RLC, *Executive Coaching and Leadership Development, President, The Sheahen Group* Mary Rooney Sheahen has held management positions at Advocate Healthcare and was President/CEO of Provena Mercy Center, a leading acute care hospital and part of Provena Health. She also served as President/CEO during a financial turnaround of Midwest Medical Center in Galena, Illinois. Mary currently serves as President of the Sheahen group, A healthcare consulting practice specializing in providing senior leadership coaching, team-building, organizational culture change management, interim executive leadership, organizational training and special project management. Mary brings 40 years of leadership experience in a hospital setting with skills in overall operations, strategic planning, performance improvement, team facilitation, organizational culture change, and staff development. Effective in collaborating with medical staff and in setting strategic directions for the organization in conjunction with the Board of Directors. Mary currently serves on three boards: she is the Board Chairperson of Northwest Community Healthcare, Board Chair of Midwest Medical Center and the Board Chair of Friendship Village. Mary serves as a coach for the Community Memorial Foundation, Lagrange, IL and is very involved in DuPage County social services.

governWell™ also extends appreciation for the review of this advisory to ***Ann Scott Blouin, RN, PhD, President & Founder, PSQ Advisory,*** *and* ***Todd Linden, MA, FACHE, President, Linden Consulting, Inc.***

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