TAHOE FOREST HOSPITAL DISTRICT

2022-05-12 Board Quality Committee Meeting

Thursday, May 12, 2022 at 9:00 a.m.

Pursuant to Assembly Bill 361, the Board Quality Committee meeting for May 12, 2022 will be conducted telephonically through Zoom.

Please be advised that pursuant to legislation 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.

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/84722817080

If you prefer to use your phone, you may call in using the numbers: (346) 248 7799 or (301) 715 8592, Meeting ID: 847 2281 7080

TAHOE FOREST HOSPITAL DISTRICT

Meeting Book - 2022-05-12 Board Quality Committee Meeting

TAHOE FOREST HOSPITAL DISTRICT

QUALITY COMMITTEE
AGENDA

Thursday, May 12, 2022 at 9:00 a.m.

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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
Michael McGarry, 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: 02/10/2022 ..... 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. TFHD Care Compare Quality Metrics ..... ATTACHMENT
Quality Committee will receive an overview of the Care Compare Quality metrics and plans for improvement.

6.5. Governance of Quality Assessment (GQA) Tool ..... ATTACHMENT
Quality Committee will receive an update on the following core process: *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.*

*(*Reference: *Framework for Effective Board Governance of Health System Quality* (2018). Daley Ullem E, Gandhi TK, Mate K, Whittington J, Renton M, Huebner J. Boston, Massachusetts: Institute for Healthcare Improvement.

6.6. Board Quality Education

6.6.1. *2022 Health Care Talent Scan (2022*). American Hospital Association. Retrieved on 1/11/22 from https://www.aha.org/aha-talent-scan **.....** ATTACHMENT

6.7. Board Quality Committee Charter..... ATTACHMENT
Quality Committee will review revisions to the committee charter.

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

Thursday, February 10, 2022 at 12:00 p.m.

Pursuant to Assembly Bill 361, the Board Quality Committee meeting for February 10, 2022 will be conducted telephonically through Zoom. Please be advised that pursuant to legislation 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. Committee Members will be participating telephonically and will not be physically present in the Eskridge Conference Room.

1. CALL TO ORDER

Meeting was called to order at 12:02p.m

2. ROLL CALL

Board: Michael McGarry, Chair; Alyce Wong, RN, Board Member

Staff in attendance: Harry Weis, President & Chief Executive Officer; Judy Newland, Chief Operating Officer (outgoing); Louis Ward, Chief Operating Officer (Incoming); Crystal Betts, Chief Financial Officer; Jan Iida, Chief Nursing Officer; Dr. Shawni Coll, Chief Medical Officer; Scott Baker, Vice President Physician Services; Janet Van Gelder, Director of Quality & Regulations; Dorothy Piper, Director of Medical Staff Services; Derek Baden; 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: 11/29/2021

Director Wong moved to approve the November 29, 2021 Board Quality Committee minutes, seconded by Director McGarry.

6. ITEMS FOR COMMITTEE DISCUSSION AND/OR RECOMMENDATION

6.1. Safety First

Dr. Shawni Coll, Chief Medical Officer, shared a Safety First topic on physicians getting proper care for patients regardless of known payment status.

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). PFAC did not meet in December 2021 or January 2022.

6.3. Patient Safety

6.3.1. BETA HEART Program Progress Report

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

Tahoe Forest Hospital (TFH) validated all five domains for two years in a row. TFH is scheduled for another validation survey in May 2022.

The Culture of Safety survey will launch on February 28, 2022. Results will be distributed to each department leader in April.

The BETA HEART Conference will be held at the end of February. It will be a live meeting. The District will have 11 attendees.

6.4. TFHD Care Compare Quality Metrics

CMO and Janet Van Gelder, Director of Quality and Regulations, provided an overview of the Care Compare Quality metrics and plans for improvement.

The preoperative clinic started in July 2021 with patient screening that helps manage risk.

Quality identified some opportunities for wound care education.

A group met with Drs. Dodd and Barta on home health trends.

There will be a focus on discharge codes to assist with readmission information.

A Substance Abuse Navigator will be added in the Emergency Room.

Surgical nurses were educated on changing antibiotics for patients with penicillin allergy.

TFH did not have any early inductions but there were not enough cases to have it reported.

6.4.1. Surgical Site Infection (SSI) Report

Svieta Schopp, Infection Control Preventionist, presented a summary report of the publicly reported SSI data and the District's prevention practices. The calculation for the Standardized Infection Ratio (SIR) was reviewed. The ratio is adjusted for risk and other factors. SIR is utilized in public reporting of surgical site infections.

Quality Committee reviewed a 2019 comparison of similar hospitals.

Infection Control Preventionist reviewed inpatient outpatient infection rates. Quality will focus on hip and knee replacements.

Infection Control Preventionist reviewed current prevention practices in place.

6.5. Governance of Quality Assessment (GQA) Tool

Quality Committee received an update on the following core process: *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.*

Framework for Effective Board Governance of Health System Quality (2018). Daley Ullem E, Gandhi TK, Mate K, Whittington J, Renton M, Huebner J. Boston, Massachusetts: Institute for Healthcare Improvement.

Scott Baker, Vice President Physician Services, reviewed updates to outpatient clinics. The second floor is being expanded to increase access for Primary Care. Physician Services is recruiting for primary care physicians that will onboard in the summer. A few retirements have pinched primary care causing an increase in access time. Next year, a big catch up for access is expected.

Director Wong heard it can take a long time to book an appointment or referral to a specialty clinic. Vice President Physician Services noted some clinical areas, such as endocrinology and gastroenterology, do not have the ability to take all referrals. Every specialty has its own challenges.

A tremendous amount of work has been focused on Behavioral Health. There is a new clinical lead in Behavioral Health.

A Project Improvement Plan was completed yesterday in the Pediatrics clinic.

Improvements are being made in access but the organization still needs more space and providers.

Derek Baden, Director of Gene Upshaw Memorial Tahoe Forest Cancer Center, said transportation barriers to healthcare access include:

- transportation infrastructure
- transportation costs
- vehicle access
- policy
- distance, time and physical burden

Twenty percent of patients are traveling in from South Lake Tahoe area.

TFHD committed to a six-month pilot for transportation. Roundtrip shuttle service will occur five days a week. TFHD received a $5,000 grant from the American Cancer Society for transportation.

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

Quality Committee reviewed the proposed QA/PI 2022 priorities. The priorities are approved by the Board of Directors annually.

The QA/PI priorities were updated to add “Focus on CMS quality star rating improvements, within the 7 measure groups, that fall below benchmark.”

The event reporting platform has been upgraded. Director Wong asked how it will be measured. Director of Quality & Regulations noted monitoring will occur through daily event reports and how many events are being reported.

Josh Fetbrandt, Quality Analyst, received training from Epic to write reports in order to maximize Epic reporting functionality. Director of Quality & Regulations left it as a priority because it is an area to continue focusing on.

6.7. Board Quality Education

6.7.1. *Final Recommendations: Future of Rural Health Care Task Force (2021).* American Hospital Association. Retrieve on 12/8/2021 from https://www.aha.org/2021-05-17-final-recommendations-future-rural-health-care-task-force-may-2021

Discussion was held on the article. Quality Committee felt it was reassuring to see items listed as recommendations are things we are already doing, especially in the area of strategic partnerships.

6.8. Board Quality Committee Charter

Quality Committee reviewed its committee charter and suggested the following changes:

-Under Purpose, update the statement to read "The purpose of the charter is to delineate the Committee's duties and responsibilities."
-Under Responsibilities, update hospital to health system.
-Under Composition, "Board President" will be updated to "Board Chair."

Director Wong inquired about the requirement for medical staff attendance at Board Quality Committee. CMO felt it would be wise to have medical staff representation on the committee. CMO would like to review the Medical Staff Rules and Regulations. Dorothy Piper, Director of Medical Staff Services, will add the topic to the agenda for next week's Medical Executive Committee meeting.

7. REVIEW FOLLOW UP ITEMS / BOARD MEETING RECOMMENDATIONS

No discussion was held.

8. NEXT MEETING DATE

The next Board Quality Committee meeting will be held on May 12, 2022 at 9:00 a.m.

9. ADJOURN

Meeting adjourned at 1:30 p.m.

Patient and Family Advisory Council (PFAC) Summary Report

January 2022 to April 2022

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

- Members who are volunteering in other areas of the hospital in addition to the monthly PFAC meetings:
    - Kevin Ward assists the Quality Department tracking our service recovery toolkits. He is also attends the quarterly Board Quality Committee meetings
    - Pati Johnson attends the quarterly Cancer Committee meetings
    - Alan Kern attends the quarterly Medical Staff Quality Committee

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

- Plan for 2022 is to continue to review patient feedback and comments from patient experience surveys, help improve quality, safety, and patient experiences. Goal is to have PFAC identify ways to help educate community on all services offered by TFHS.

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

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

- February: Theresa Crowe, our Risk Manager, presented on our partnership with BETA HEART.

- March: Scott Baker presented an update on the increased number of PCPs and Specialists. Addressed the concurrent demands of population growth such as increased provider visits, getting patients in quickly and avoiding the need for ER/urgent care visits. Jan Iida, Chief Nursing Officer, was introduced to inform us of goals to improve discharge communication process.

- April: Claire da Luz and Eileen Knudson presented information on the Substance Use Program and the position of Substance Use Navigator. Addressed community statistics reflecting the growing needs to address mental and behavioral health along with substance use.

- 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 17, 2022

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. Violet Nakayama	10/31/2019
10. Alan Kern	2/20/2020
11. Kathee Hansen	4/1/2021

Beta HEART Progress Report for Year 2022

(April 2022)

Beginning in 2020, Beta Healthcare Group changed their annual Incentive process to be "Annual", meaning that each year the five (5) domains have to be re-validated each year to be eligible for the incentive credit. General updates for 2022:

- Beta Heart Validation Survey completed on 5/11/21 with validation in all 5 domains with a total cost savings of $108, 652.00.
- Beta Heart Validation Survey scheduled for May 25-26, 2022

Domain	History of Incentive Credits (2% annually)	Readiness for next Validation	Goal	Comments
Culture of Safety: A process for measuring safety culture and staff engagement (Lead: Lorna Tirman, Beta Heart Lead)	Validated 2019: $13,101 2020: $19,829 2021:$21,730.40	100%	Goal= Greater than 85% Response rate RR 84%	Culture of Safety survey completed with a response rate of 84% Reports have been distributed to all department leaders and debrief sessions will take place May through July 2022 by HR and department leaders. Each department will identify their top 2 priorities to focus on.
Rapid Event Response and analysis: A formalized process for early identification and rapid response to adverse events that includes an investigatory process that integrates human factors and systems analysis while applying Just Culture principles (Lead: Theresa Crowe, Risk Manager)	Validated 2020: $19,829 2021:$21,730.40	100%	Reinforce education related to timely event reporting and implementation of corrective action items.	TFHD incorporates the transparent and timely reporting of safety events to ensure rapid change in providing safer patient care. All investigations utilize "just culture" and high reliability principles and encourage accountability. 11 leaders attended Beta Heart Workshop in Los Angeles in February, 2022. 10 leaders attended Beta Heart workshop in Laguna Beach, April, 2022.
Communication and transparency: A commitment to honest and transparent communication with patients and family members after an adverse event (Lead: Theresa Crowe, Risk Manager)	Validated 2020: $19,829 2021: $21,730.40	100%	Reinforce Beta HEART principles through targeted education at meetings, emails, Pacesetter, weekly Safety First, etc.	Disclosure checklist updated and refined as we update process and leaders trained to respond to events.
Care for the Caregiver: An organizational program that ensures support for caregivers involved in an adverse event (Lead: Stephen Hicks, Peer Support Lead)	Validated 2020: $19,829 2021: $21,730.40	100%	Proactive support to peers, not just after adverse events	Ongoing training and monthly peer support meetings. Currently have 20 peer supporters available to all staff. Sunshine cart rounds weekly to remind everyone about talk space, peer support and Employee Assistance Program. Courageous conversations recorded monthly, and posted on intranet.
Early Resolution: A process for early resolution when harm is deemed the result of inappropriate care or medical error (Lead: Theresa Crowe, Risk Manager)	Validated 2020: $19,829 2021: $21,730.40	100%	"Pacesetter Article" and "Safety Firsts" to enforce the principles of the 5 Domains	Early Resolution is the final domain, and is only achieved by successfully completing all 4 prior domains. TFHD utilizes the BETA Heart Dashboard to monitor the effectiveness of meeting these goals. Plan to send at least 12 leaders to October 2022 training.

Date	Define	Measure	Analyze	Improve	Control	Process Improvement Implemented
5/21/2021	Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and Total Knee Arthroplasty (TKA)	COMPLICATION-HIP-KNEE is the metric identifier with Centers for Medicare & Medicaid Services (CMS).	Reviewed Health Services Advisory Group (HSAG) claims data to identify complications. Developed complication report for concurrent review & follow up. Multidisciplinary team meets weekly to review data. Quality Analyst to develop complication report for concurrent and retrospective review. Multidisciplinary team working on pulmonary emboli order set, including adding PESI score.	1. Coders will send Health Information Management (HIM) Director all retrospective complications for Quality or Infection Preventionist, and physician review prior to submitting the claim for payment. Concurrent review of identified complications. Refer to physician if documentation revisions are needed. 2. Develop and educate staff to the pulmonary emboli order set, including Pulmonary Embolism Severity Index (PESI) score flowsheet in Mercy Epic. 3. Share complication report with Orthopedic RN Navigator to assist with tracking & trending. 4. Met with Orthopedic Medical Director & Surgery Department Chair in December to review Surgical Site Infection (SSI) Standardized Infection Ratio (SIR) rates & discuss areas for improvement. Report reviewed at Surgery Department meeting on 1/10/22. 5. All Total Joint Replacement (TJRs) are referred to Preoperative Clinic to optimize the patient for surgery. Ortho Navigators address patient co-morbidities and appropriateness for surgery, especially revision surgeries. 6. Orthopedic RN Navigators to refer patients to Home Health Agency (HHA) Physical Therapy (PT), based on establishted criteria, for preoperative home assessment. Determine if we can conduct preoperative visits to determine HHA/PT needs postoperatively. Orthopedic Physician Assistant (PAs) can complete the HHA order form & have the Medical Doctor (MD) sign. Pursue establishing a partnership with Sierra/Plumas County HHA PT. 7. Enhanced Recovery after Surgery (ERAS®) nutritional supplement program ($43) for all TJR patients, except for patients with a diabetic medical history, effective 3/1/22 that will include incentive spirometer. Establishing inclusion & exclusion protocol for the nutritional supplement.	Concurrent review of complications to identify root causes and ensure identified plans for improvement are effective.	Educated physicians & Registered Nurse (RN) staff regarding utilization of Ancef despite history of rash or other allergic reaction. Also administering additional antibiotic dose if surgery greater than 2 hours long. Continue to explore implementation of preoperative home assessment visits by PT. Orthopedic surgical patients receiving ERAS nutritional supplements effective 3/1/22. Different protocol for diabetic mellitus patients.
5/21/2021	Hospital-Level 30-Day All-Cause Risk-Standardized Readmission Rate (RSRR) Following Elective Total Hip Arthroplasty (THA)/Total Knee Arthroplasty (TKA)	READMISSION (READM)-30-Hip-Knee is the metric identifier with CMS.	Reviewed Health Services Advisory Group (HSAG) claims data to identify root causes. Developed daily readmission report for concurrent review & follow up. Developed readmission report 1/1/2019 thru present. Plan to review cases from 7/1/2020 thru present to identify root causes. Additional focus & review of home health patient readmissions. Multidisciplinary team meets weekly to review data.	1. HHA revised the discharge criteria to ensure appropriate patient LOS based on diagnosis and care coordination needs. 2. Nursing Case Management (NCM) to review & forward HHA leadership concurrent readmission audit report for their review & follow up. HHA leadership reviews all HHA readmissions to identify areas for improvement. 3. NCM auditing all discharge codes for accuracy. Coders will validate discharge codes. 4. NCM to review & forward surgical readmissions to Quality Director for Medical Staff review. 5. NCM continue to monitor appropriate admit status using Interqual for all patients to ensure accuracy. Consider admitting to IP if patient requires SNF placement & 3 day qualifying stay. 6. NCM to review & forward Orthopedic leadership & Ortho Navigator concurrent readmission audit report for their review & follow up. 7. Total Care Management (TCM) patient follow up visit within 7 days as part of HHA protocol. 8. Ensure Primary Care Physician (PCP) follow up appointment is scheduled prior to patient discharge. Explore postoperative clinic. 9. Conduct Senior Services resources gap analysis to identify community needs and identify plans for improvement. 10. Preoperative Clinic instituted in July 2021 with evidence based screening criteria to optimize patient selection and manage risk. 11. Explore Extended Care Center/ Long Term Care (ECC/LTC) bed hold for swing status type patient access to bed post acute care stay that need additional rehabilitation services. 12. Follow chain of command if Orthopedic Care Coordinators have concerns with a planned surgery and the physician does not agree with their assessment to delay the surgery.13. Meeting in January 2022 with Hospitalists, ED Chair, and NCM to discuss admissions and opportunities for improvement. 14. HHA & Rehab Services leadership meeting with Orthopedic Medical Director on 11/29/21 to discuss referrals. 15. Orthopedic RN Navigators to refer patients to HHA PT, based on establishted criteria, for preoperative home assessment.	Concurrent review of readmissions to identify root causes and ensure identified plans for improvement are effective.	Met with Orthopedic Medical Director on 11/29/21 to discuss opportunities for improvement. Rehabilitation Services is exploring preoperative assessment. Orthopedic Medical Director concerned about this in regards to potential impact on postoperative PT intervention insurance benefits. We are considering if a PT Aide can conduct the preoperative assessment with a designated checklist. PT must do initial asssessment before PT Aide can conduct home visit. Goal is to not delay the surgery and the Orthopedists will likely support.
7/14/2021	Emergency Department (ED) Visits for Patients Receiving Outpatient Chemotherapy	Outpatient (OP)-35 Emergency Department (ED) is the metric identifier with CMS.	Review readmission metric and data with ED & Cancer Center Medical Director & Nursing leadership. Information Technology Business Intelligence Analyst developed report for concurrent and retrospective chart audit to identify root causes.	1. Meeting with Medical Oncologists & Cancer Center (CC) leadership in December to discuss palliative care; expanding RN triage; & MD assessment prior to infusion center discharge. 2. Continue to conduct chart audits of all readmissions to identify trends and plans for improvement. 3. Review findings at quarterly Cancer Committee meeting.	Concurrent review of readmissions to identify root causes and ensure identified plans for improvement are effective.	Educate Oncologists & ED providers. Utilize Primary Care Clinic (PCC) after hours & weekends for intravenous (IV) hydration if needed.

2/1/2018	Clostridium Difficile (C.difficile)	Hospital Acquired Infection (HAI)-6 is the metric identifier with CMS.	Daily review of Clostridium Difficile (C.difficile) testing and reporting at Safety Huddle.	1. Infection Preventionist contacted by staff before ordering test to ensure appropriateness. Laboratory staff rejects specimen if not appropriate. 2. C-difficile education & educational cards provided for Medical & Nursing staff. 3. Meeting with Hospitalists in January 2022 to review ordering criteria and order approvals by Chief Medical Officer (CMO) or Infectious Disease (ID) MD. 4. Create a hard stop in Electronic Health Record (EHR). 5. Continuing Medical Education (CME) by ID MD in 2022 on when to order testing. 6. Pharmacist participate in daily rounds and assist with antibiotic recommendations; by reviewing culture results and recommending changes as needed.	Daily review of Clostridium Difficile (C.difficile) testing to ensure identified plans for improvement are effective.	Dr. Hovenic educated ED & Hospitalists regarding testing. RN staff education regarding testing. Redistribute HASG cards to all staff.
5/21/2021	Hospital-Wide All-Cause Unplanned Readmission (HWR)	READM-30-HOSP-WIDE is the metric identifier with CMS.	Reviewed HSAG claims data to identify root causes. Developed daily readmission report for concurrent review & follow up. Developed readmission report 1/1/2019 thru present. Plan to review cases from 7/1/2020 thru present to identify root causes. Additional focus & review of home health patient readmissions. Multidisciplinary team meets weekly to review data.	1. HHA revised the discharge criteria to ensure appropriate patient length of stay (LOS) based on diagnosis and care coordination needs. 2. NCM to review & forward HHA leadership concurrent readmission audit report for their review & follow up. HHA leadership reviews all HHA readmissions to identify areas for improvement. 3. NCM auditing all discharge codes for accuracy. Coders will validate discharge codes. 4. NCM to review & forward surgical readmissions to Quality Director for Medical Staff review. 5. NCM continue to monitor appropriate admit status using Interqual for all patients to ensure accuracy. Consider admitting to IP if patient requires SNF placement & 3 day qualifying stay. 6. NCM to review & forward Orthopedic leadership & Ortho Navigator concurrent readmission audit report for their review & follow up. 7. TCM patient follow up visit within 7 days as part of HHA protocol. 8. Ensure PCP follow up appointment is scheduled prior to patient discharge. Explore postoperative clinic. 9. Conduct Senior Services resources gap analysis to identify community needs and identify plans for improvement. 10. Preoperative Clinic instituted in July 2021 with evidence based screening criteria to optimize patient selection and manage risk. 11. Explore ECC/LTC bed hold for swing status type patient access to bed post acute care stay that need additional rehabilitation services. 12. Follow chain of command if Orthopedic Care Coordinators have concerns with a planned surgery and the physician does not agree with their assessment to delay the surgery.13. Meeting in January 2022 with Hospitalists, ED Chair, and NCM to discuss admissions and opportunities for improvement. 14. HHA & Rehab Services leadership meeting with Orthopedic Medical Director on 11/29/21 to discuss referrals. 15. Orthopedic RN Navigators to refer patients to HHA PT, based on establishted criteria, for preoperative home assessment. 16. Implementation of the Substance Abuse RN Navigator in the ED is assisting with patient management and decreasing potential admissions.	Concurrent review of readmissions to identify root causes and ensure identified plans for improvement are effective.	Met with Hospitalists on 1/5/22 to explore opportunities for improvement
7/14/2021	Admit Decision Time to ED Departure Time for Admitted Patients	ED-2b is the metric identifier with CMS.	Review readmission metric and data with ED & Hospitalist Medical Director & Nursing leadership. Clinical Integration Analyst sending monthly reports to Chief Nursing Officer (CNO), ED Medical & RN Director/Manager.	1. ED MD will note admit time after they complete patient work up and notify the Hospitalist of the admission. 2. Nursing staff will limit the admission holds to 30 minutes or less during change of shift.	Concurrent review of ED to inpatient admission data to identify root causes and ensure identified plans for improvement are effective.	Educate ED providers to document admit time once Hospitalist contacted & work up completed.
7/16/2021	Abdomen CT Use of Contrast Material	OP-10 is the metric identifier with CMS.	Review abdomen Computerized Tomography (CT) use of contrast material metric and data with Diagnostic Imaging Medical Director & leadership. DI Medical Director to review American College of Radiology (ACR) appropriate criteria with Medicine Department & ED Department related to abdominal CT orders.	1. Medicine & ED providers to follow ACR appropriate criteria when ordering abomen CT scans. 2. Technologist will contact the ordering physician if diagnostic test ordered is incorrect or not following ACR guidelines and ask for Radiologist input if still not clear. 3. Meeting with Primary Care Committee in December to discuss ordering practices and best practice recommendations. 4. DI staff to screen Outpatient testing orders from non TFHD Medical Staff providers to ensure following ACR critera. 5. Review at ED and Medicine Department meeting in January/February 2022.	Concurrent review of abdomen CT use of contrast material to identify root causes and ensure identified plans for improvement are effective.	Educate ED and Medicine Department providers
7/14/2021	Admissions for Patients Receiving Outpatient Chemotherapy	OP-35 Admission (ADM) is the metric identifier with CMS.	Review readmission metric and data with ED & Cancer Center Medical Director & Nursing leadership. Information Technology Business Intelligence Analyst developed report for concurrent and retrospective chart audit to identify root causes.	1. Meeting with Medical Oncologists & CC leadership in December to discuss palliative care; expanding RN triage; & MD assessment prior to infusion center discharge. 2. Continue to conduct chart audits of all readmissions to identify trends and plans for improvement. 3. Review findings at quarterly Cancer Committee meeting.	Concurrent review of readmissions to identify root causes and ensure identified plans for improvement are effective.	Educate Oncologists, ED and Hospitalist providers. Utilize PCC after hours & weekends for IV hydration if needed.

Quality Presentation

– May 12, 2022

Maria Martin, MPH, RDN
Director Community health, Wellness Neighborhood, & QIP

Lizzy Henasey, MPH
Population Health Analyst

EVALUATION OF CARE OUTCOMES BASED ON RACE, SEX, ETHNICITY, LANGUAGE, SOCIOECONOMIC STATUS/PAYER TYPE, AND AGE

Treat Me with Respect: Equitable and Patient-Centered Care

(Framework for Effective Board Governance of Health System Quality: Category 4, Number 5)

AGENDA

Review disaggregated data:

- Depression Screening
- Hypertension, Controlling Blood Pressure
- Diabetes, Poor Control

Discussion:

- Possible Healthcare Disparity Factors
- Areas for Improvement and Next Steps

Depression Screening in Primary Care

Goal: Increase early identification of mental health needs and ultimately improve patient mental/behavioral health through follow up care and pre/post depression screenings

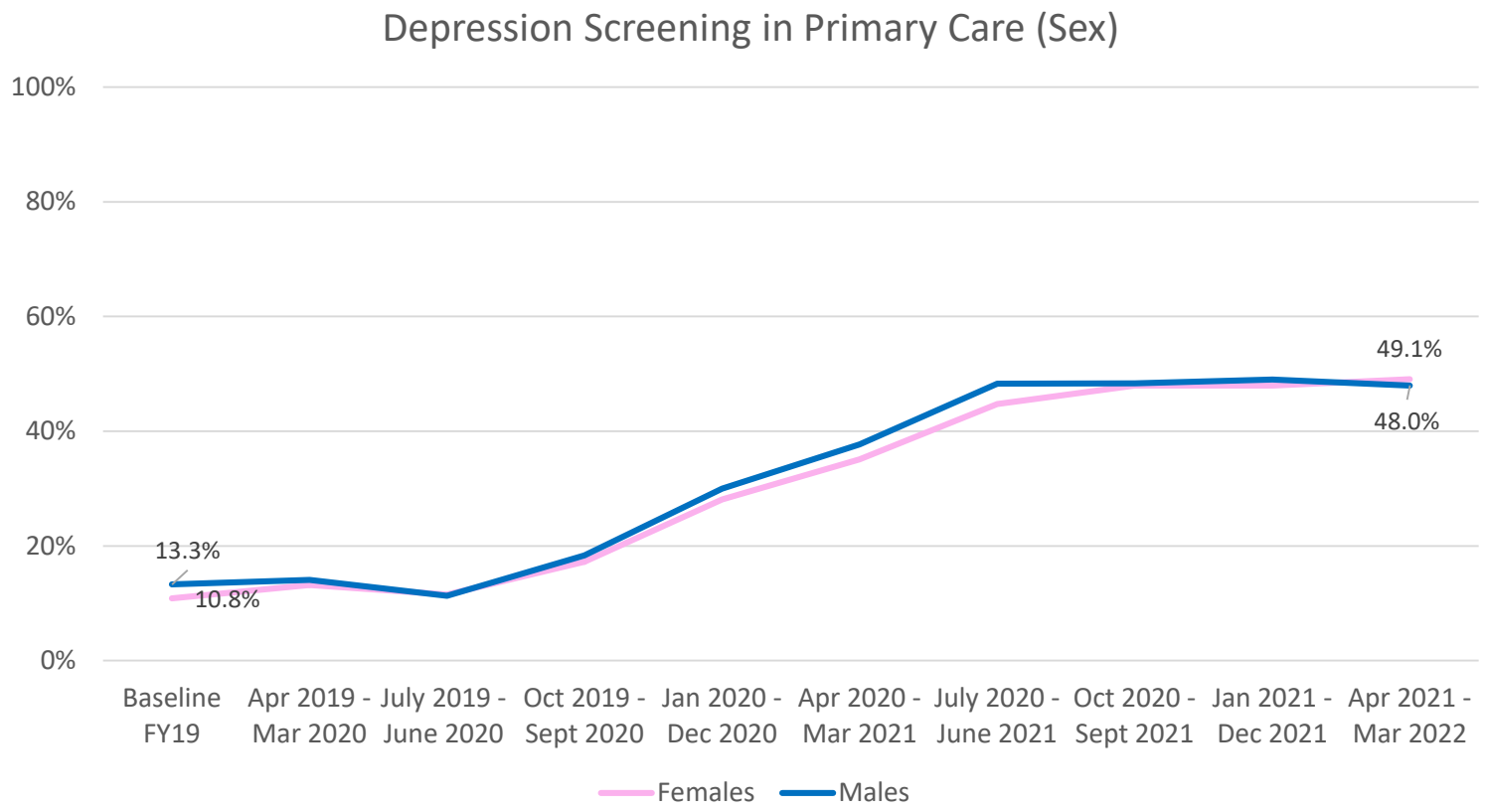
Adult Primary Care – Screen every patient at every visit

Youth Primary Care (ages 12-17) – Screen at Well Child visits

Graphs display unique patients screened at least once during the 12-month period in Primary Care.

Depression Screening results by Sex

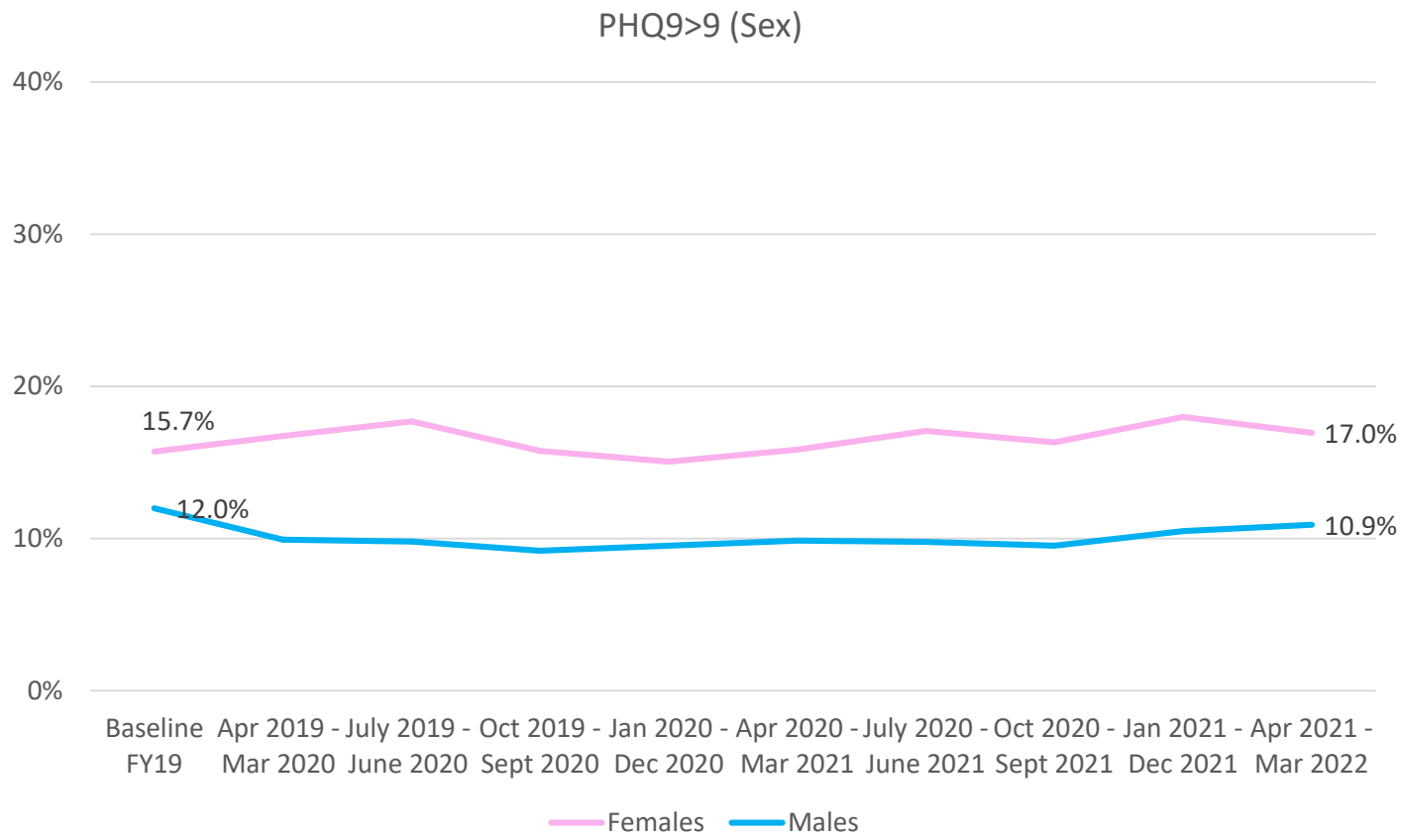
Both males and females are screened at about the same rate
Males 48%
Females 49.1%



Elevated Depression Screening Scores by Sex

PHQ* Score Greater than 9 (at risk)

Females have a higher rate of elevated Depression screening scores (PHQ>9)

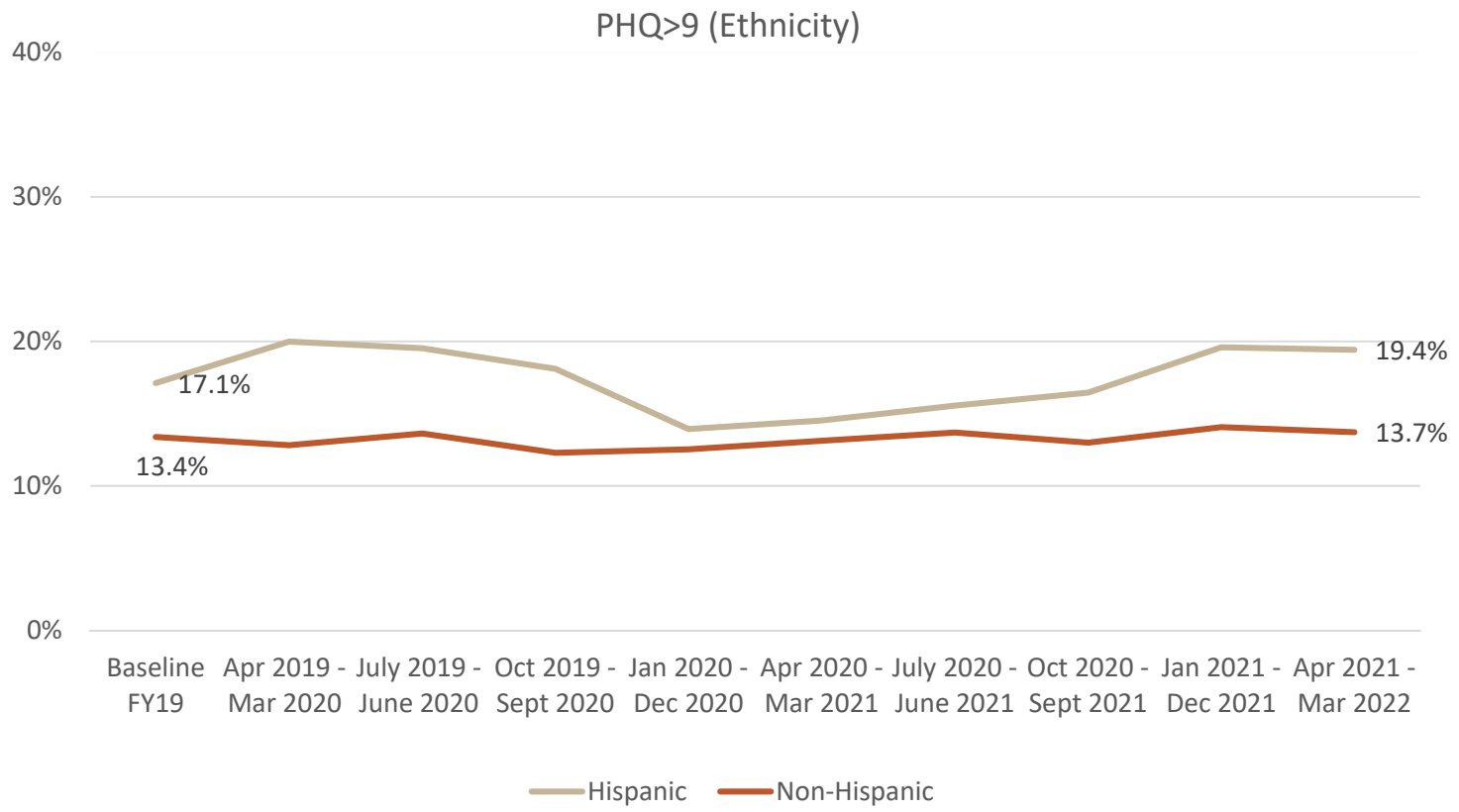


PHQ- Patient Health Questionnaire *– an evidenced based screening tool to identify individuals at risk for depression*

Elevated Depression Screening Scores by Ethnicity

PHQ Score Greater than 9 (at risk)

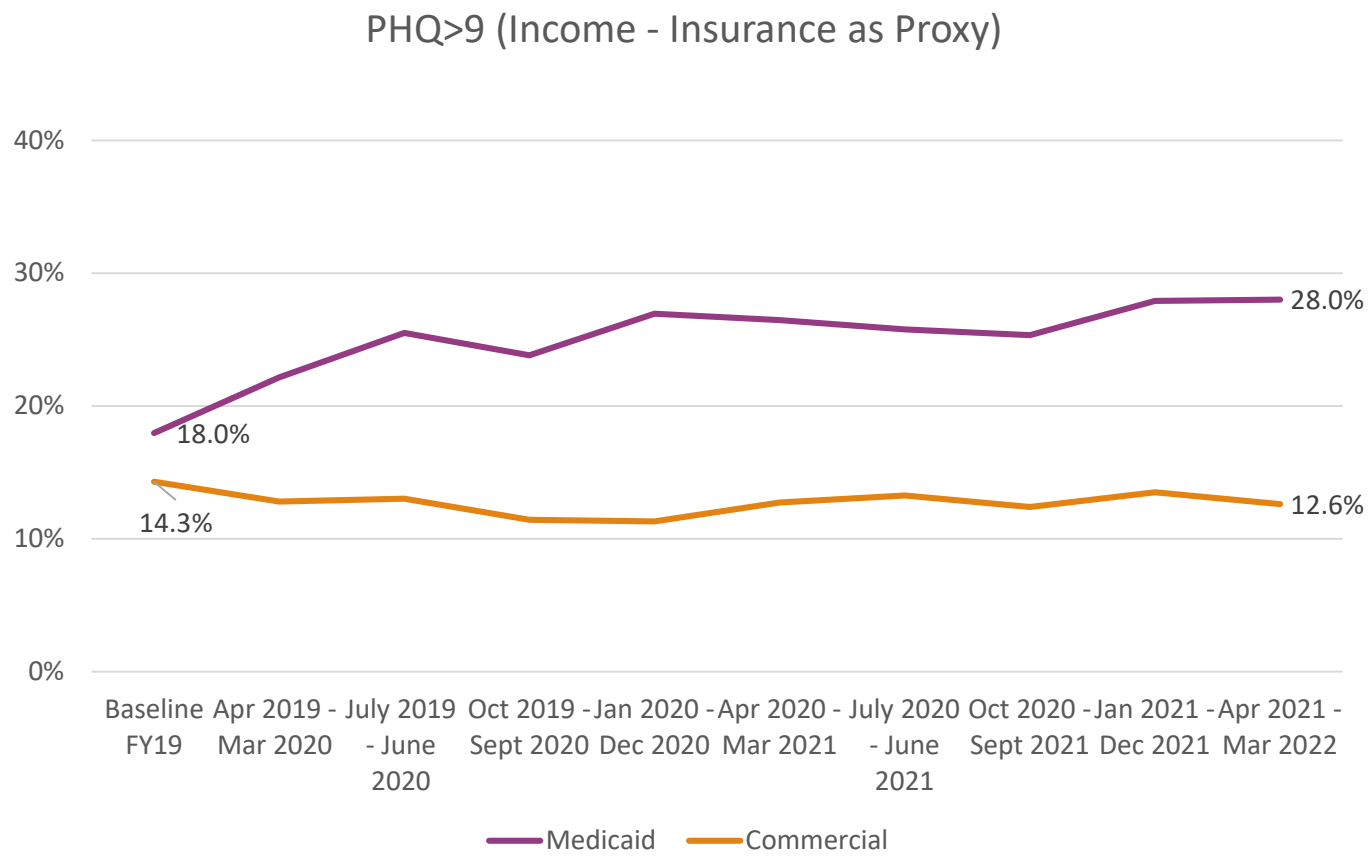
Hispanic patients have a higher rate of elevated Depression screening scores (PHQ>9)



Elevated Depression Screening Scores by Insurance (Proxy for income)

PHQ Score Greater than 9 (at risk)

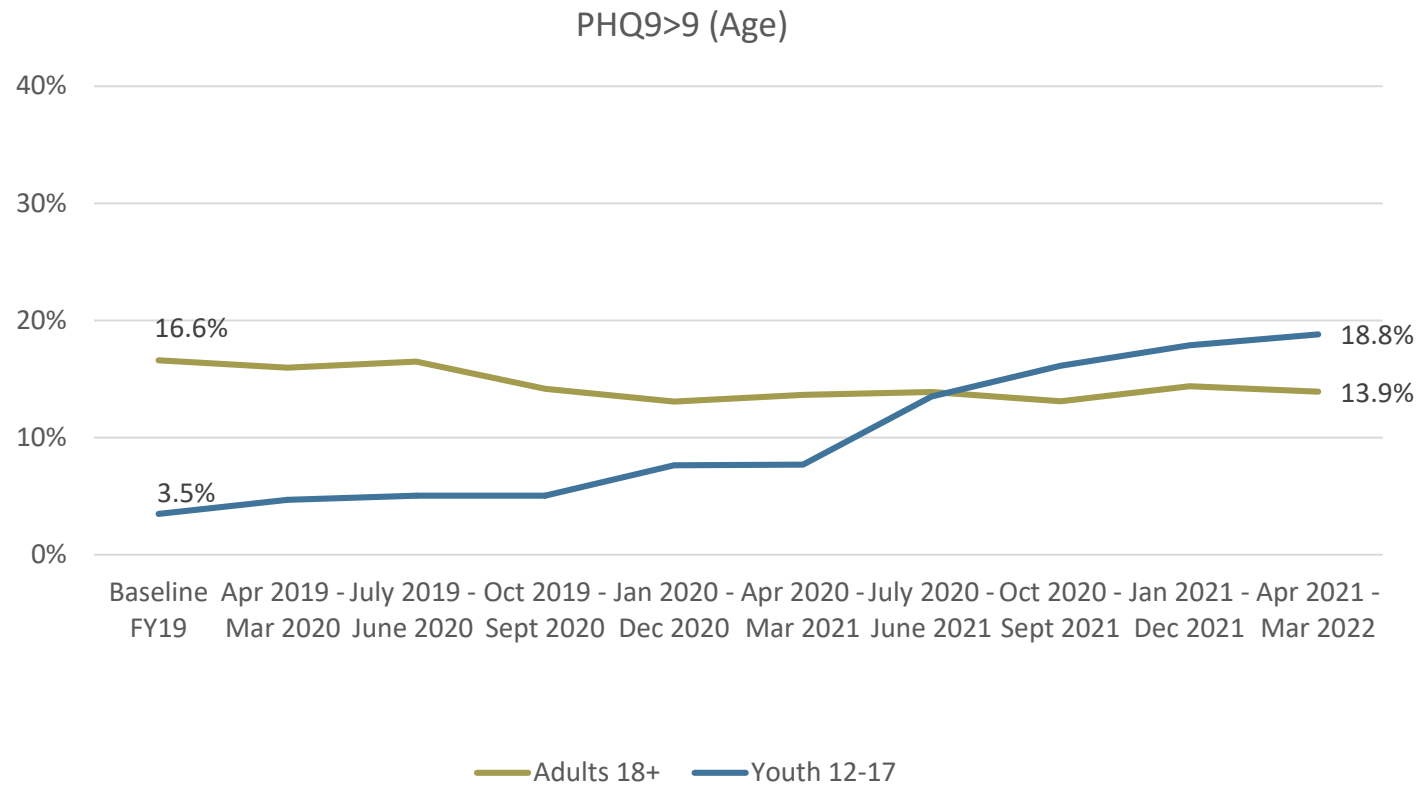
Medicaid/Medi-Cal patients have a higher rate of elevated Depression screening scores (PHQ>9)



Elevated Depression Screening Scores by Age

PHQ Score Greater than 9 (at risk)

Youth have a higher rate of elevated Depression screening scores (PHQ>9)

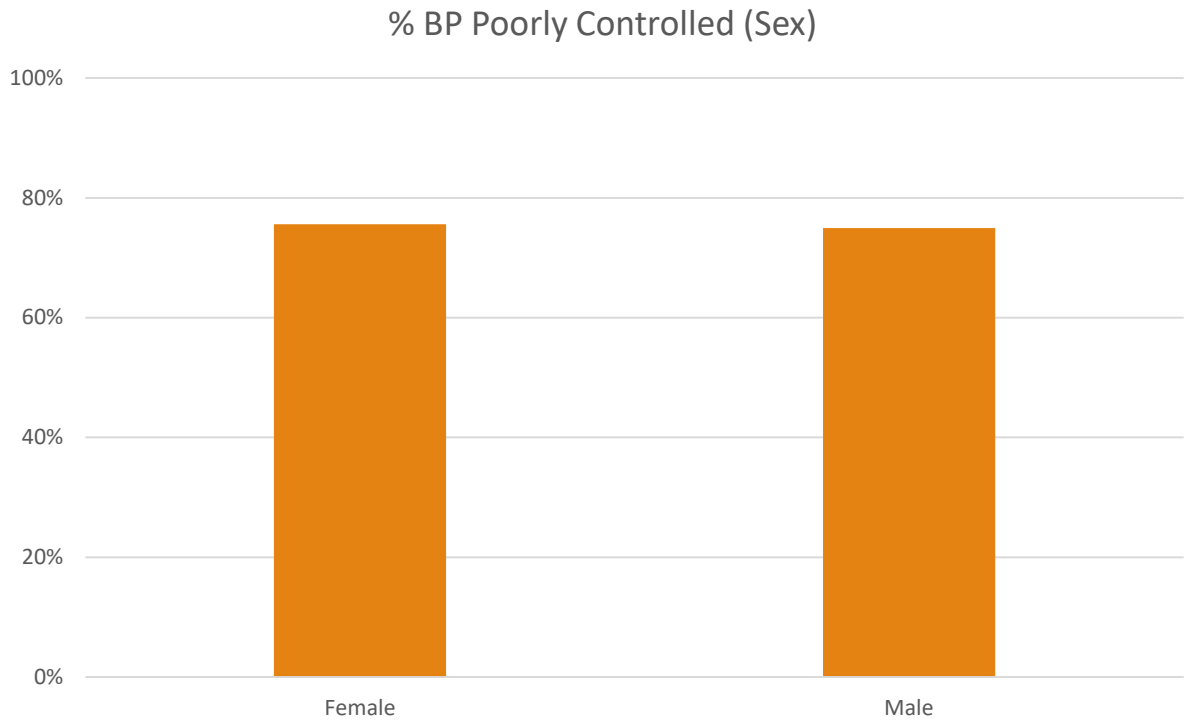


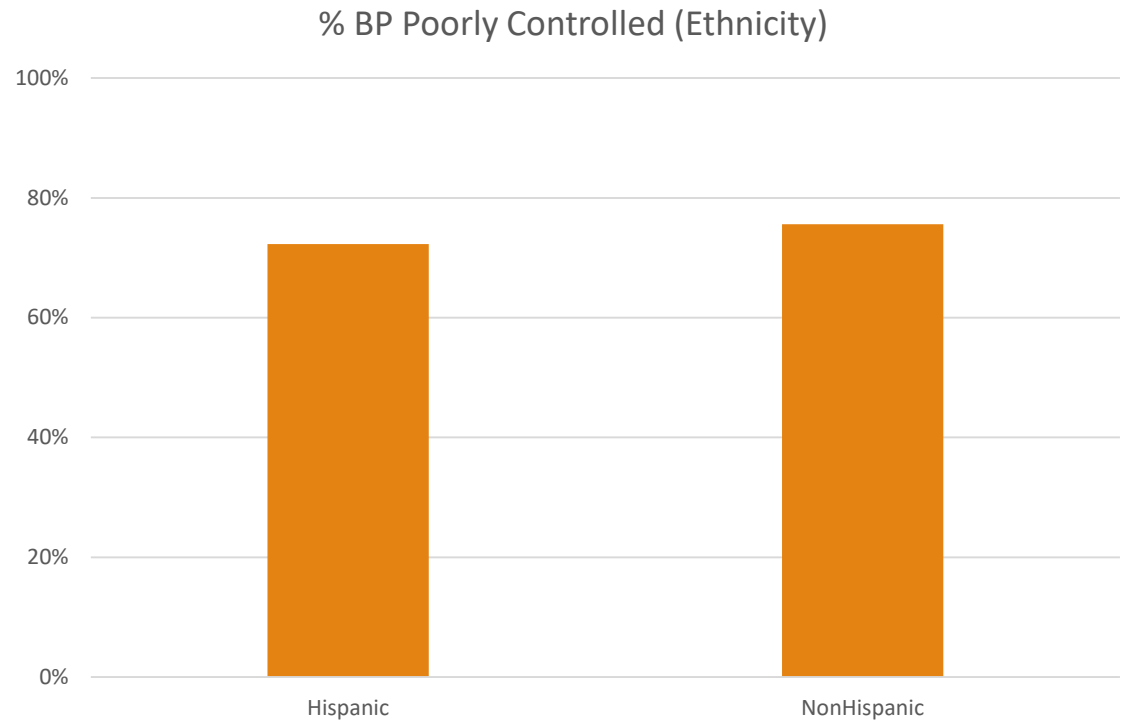
Data show that Females, Youth, Hispanic, and Medi-Cal/Low-Income community members are at greater risk of depression

How do we use this data for Quality Improvement and Equitable Care?

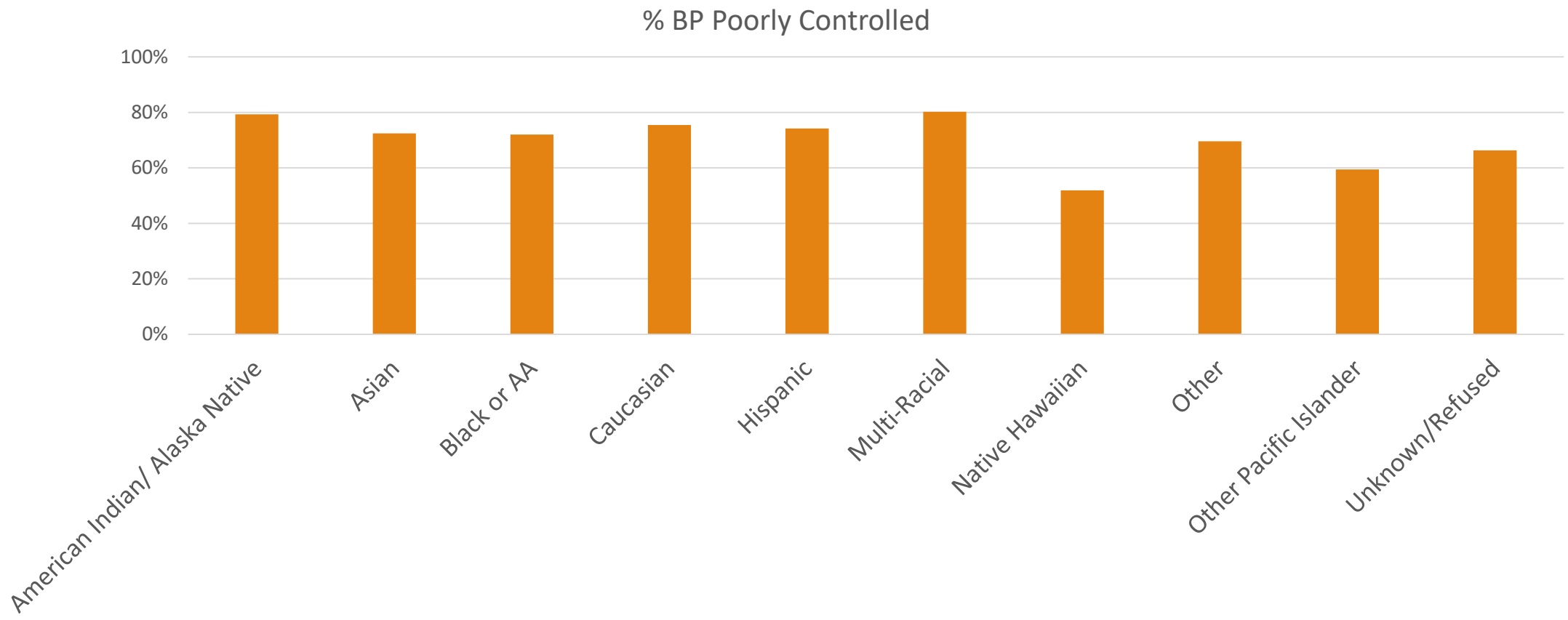
- Ensure that across populations, our screening rates are similar. If there are variations, address them.
- We share this information with community partners and providers to increase awareness of patients at greatest risk.
- Advocate for additional supports for the subpopulations at greatest risk: bi-lingual/bi-cultural; youth
- Allocated CHA/Promotora staff to support the TFHS Behavioral Health Team
- Community-based Hispanic Peer Counselors

Controlling Blood Pressure by Sex and Ethnicity
(Nov 2017- Mar 2022)

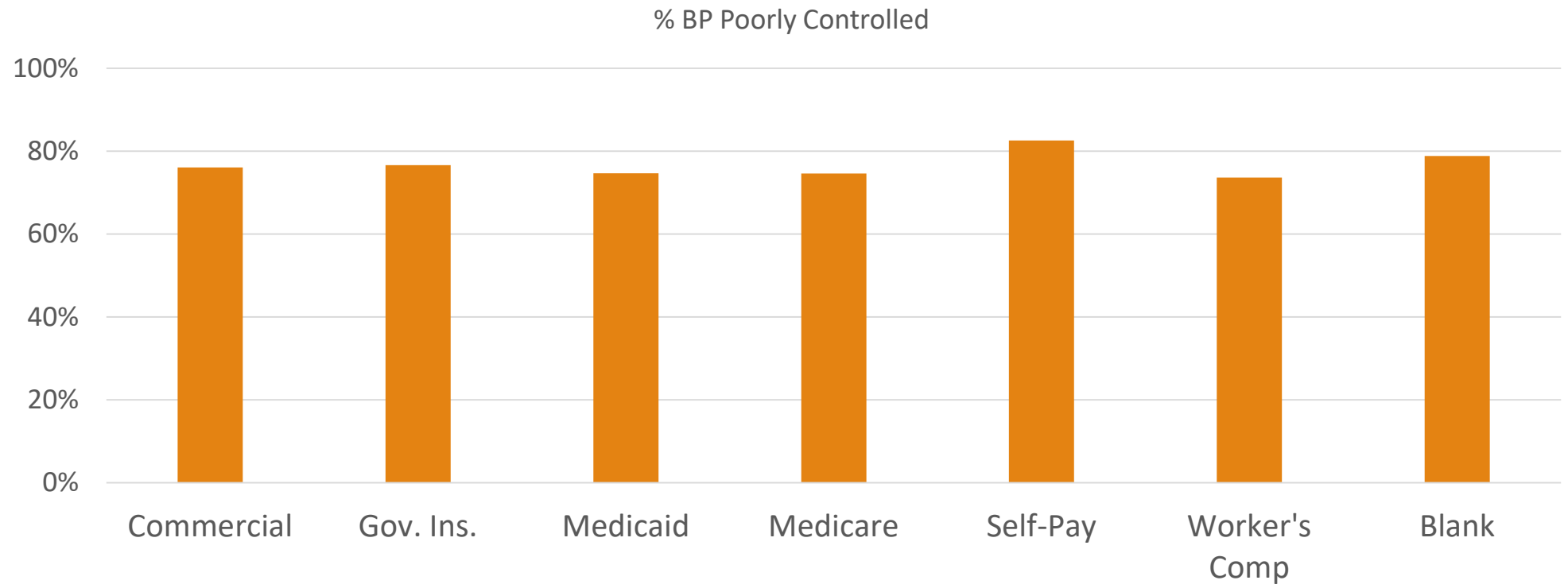




Controlling Blood Pressure by Race
(Nov 2017- Mar 2022)



Controlling Blood Pressure by Insurance
(Nov 2017- Mar 2022)



How can we use this Blood Pressure data for Quality Improvement?

There is room for improvement with all sub populations. The majority of patients who have been diagnosed with hypertension are poorly controlled.

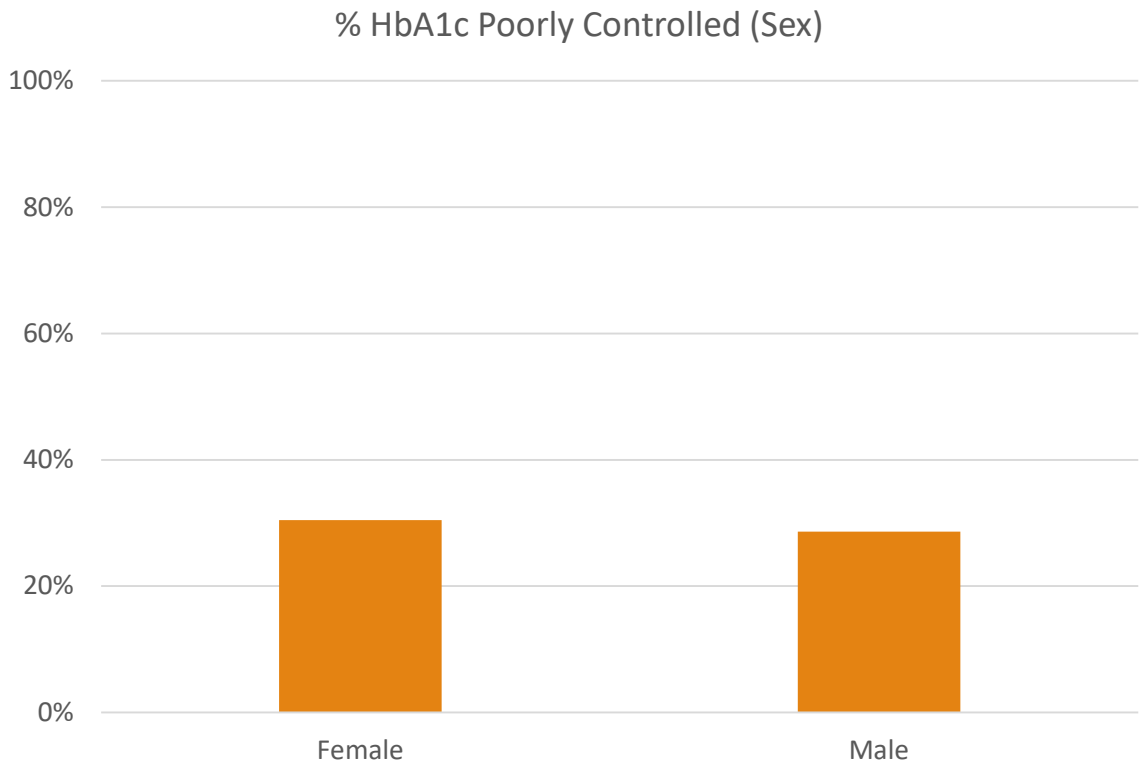
Need for universal, community health messaging and outreach about Blood Pressure control (testing, medication, diet, activity).

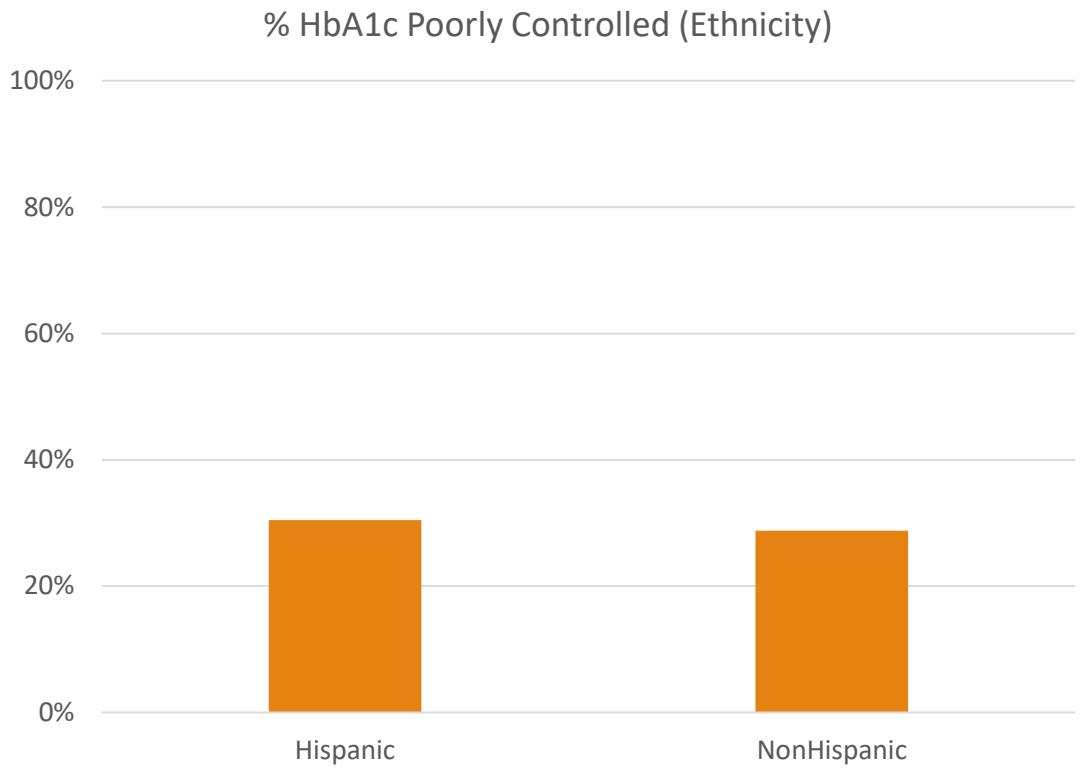
Need for provider education around updated guidelines and how to better support patients.

Promote culturally appropriate interventions (i.e. DASH Diet, activity)

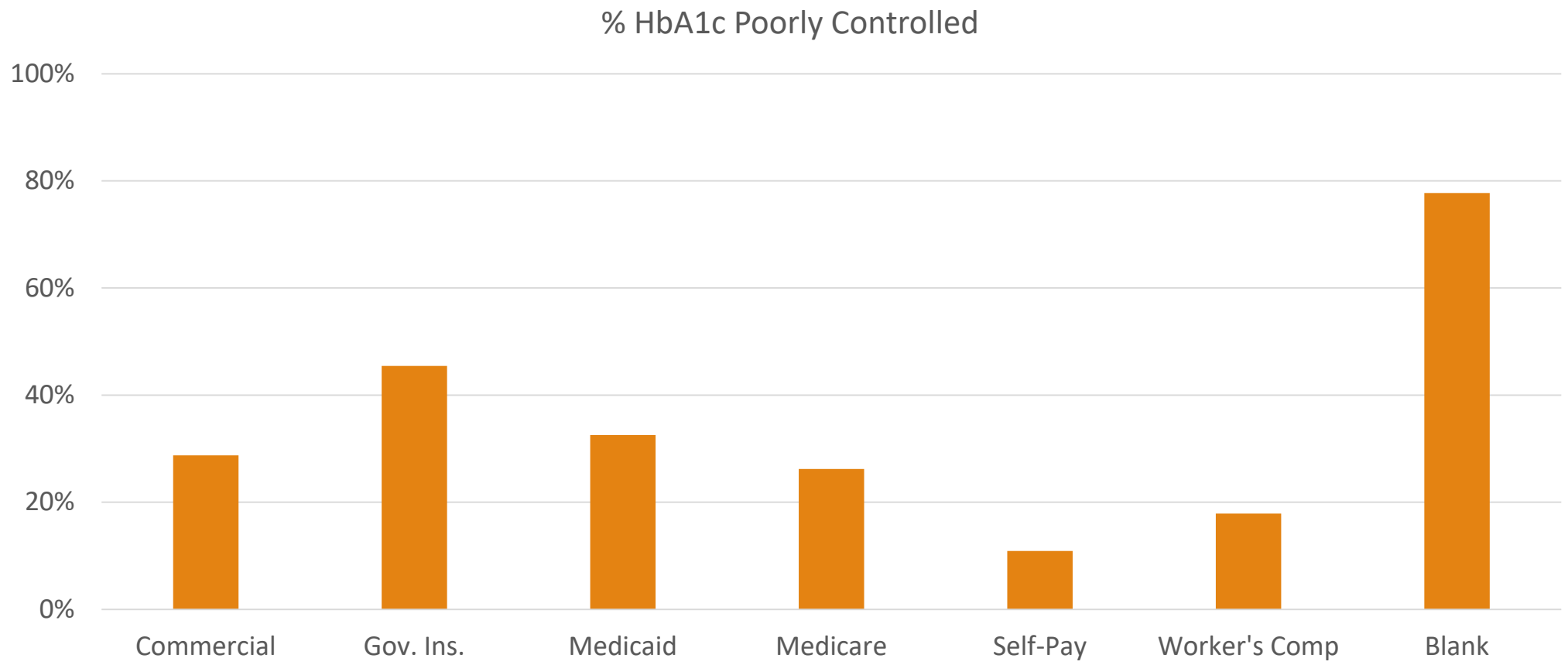
Community-based Blood Glucose and Blood Pressure Monitoring at local events

Diabetes Poorly Controlled by Sex & Ethnicity
(Mar 2020 – Feb 2022)





Diabetes Poorly Controlled by Insurance
(Mar 2020 – Feb 2022)



How can we use this HbA1c data for Quality Improvement?

Most patients diagnosed with Diabetes have their A1c under control (≤ 9) regardless of sex, ethnicity or insurance coverage.

Significant TFHS resources have been dedicated to diabetes management including:

- Multi-disciplinary Diabetes Coalition (endocrinologist, dietitian, care coordinators, etc.)
- Diabetes Self Management Program (bilingual/bicultural)
- Diabetes Prevention Program (bilingual/bicultural)
- Endocrinologist
- Community-based Blood Glucose and Blood Pressure Monitoring at local events

Possible Healthcare Disparity Factors

- Social determinants of health (e.g. education, income, access to healthy food, zip code)
- Lifestyle Choices
- Care-seeking behavior of patients which may vary due to differing cultural beliefs
- Linguistic barriers
- Degree of trust of healthcare providers
- Ability to pay for care (directly or through insurance coverage)
- Location, management, and delivery of health care services
- Beliefs of healthcare practitioners

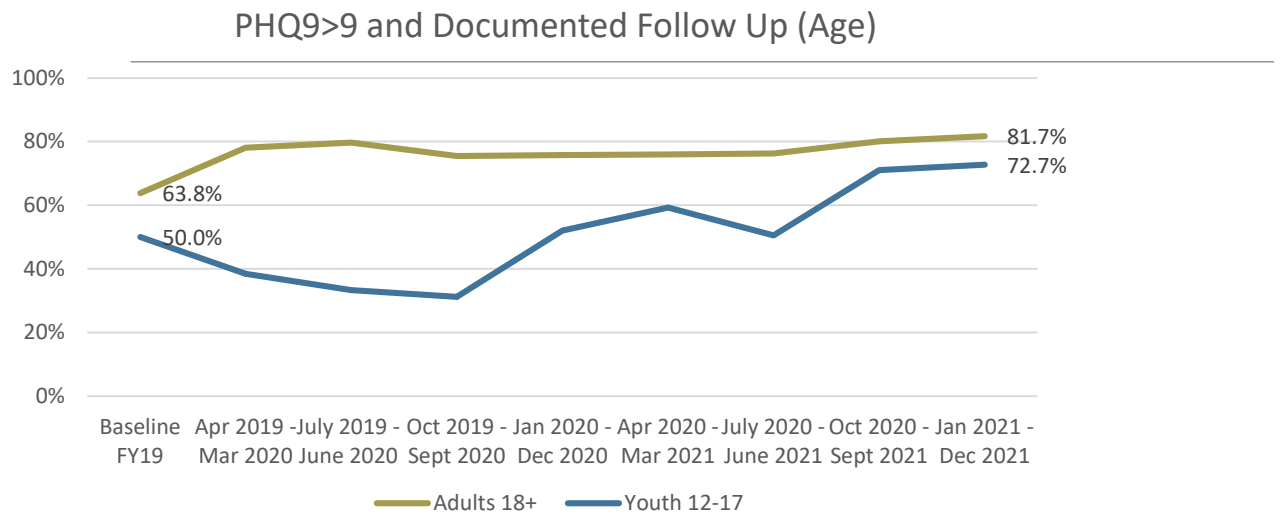
Information from: HHS Office of Minority Health

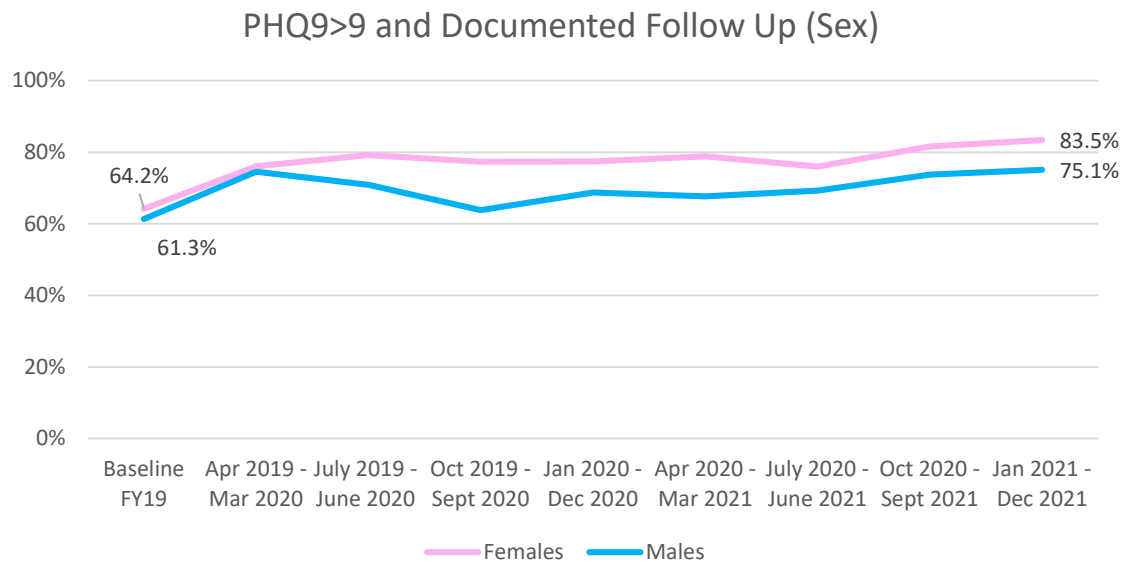
Data Collection and Stratification Next Steps

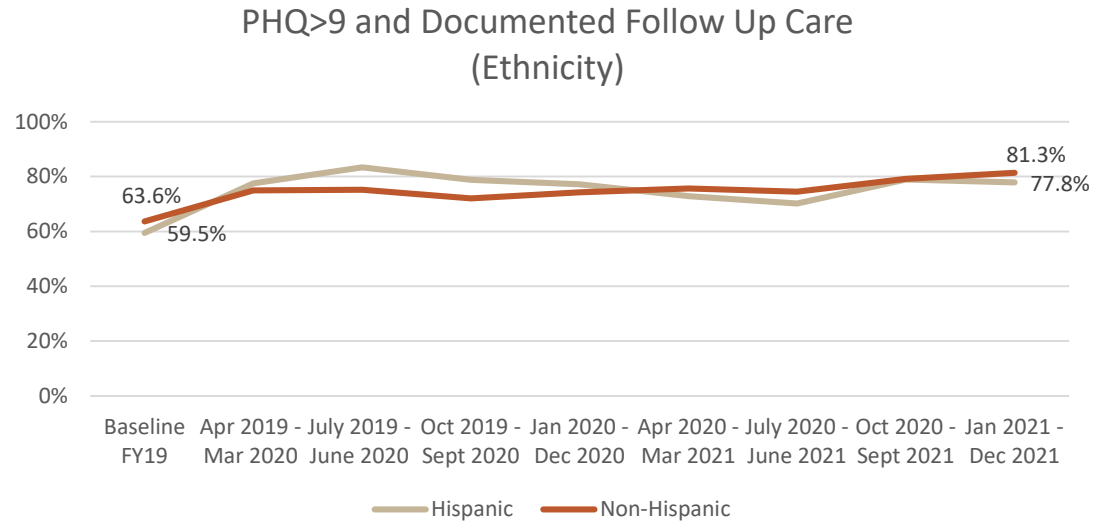
TFHS has limited access to patient outcome data that is stratified by race, sex, ethnicity, language, socioeconomic status/payer type, and age.

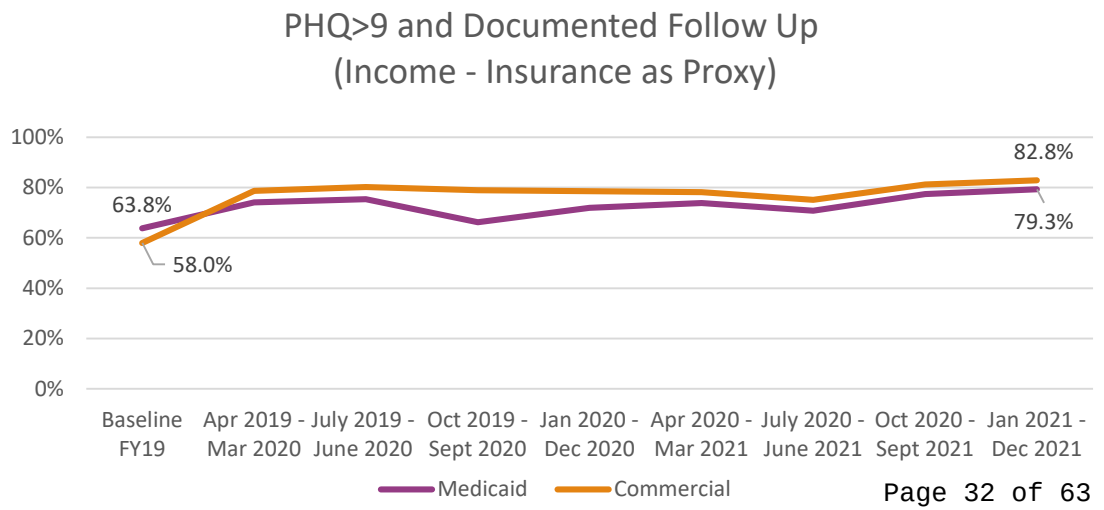
- Strategic Plan for disaggregating and analyzing data to identify disparities in outcomes across TFHS departments.
- Explore additional data management and analysis resources
- Implement data driven improvements interventions to close the gaps in outcomes that are identified as disparities in care

PHQ9>9 and Follow Up Care
(Unique Patients)









American Hospital Association™

Advancing Health in America

AMERICAN HOSPITAL ASSOCIATION

2022 HEALTH CARE TALENT SCAN

Welcome

2022 American Hospital Association Health Care Talent Scan

These past 20 months have been unlike any other that our nation and our health care system have ever experienced. Yet through it all, physicians, nurses and all team members at our hospitals and health systems continue to demonstrate their steadfast commitment to caring for their patients and communities with skill and compassion.

When we emerge from the COVID-19 pandemic into our new normal, we will understand even more clearly that our dedicated workforce is the backbone of our health care system. Pandemic or not, delivering high-quality patient care depends on our ability to recruit, train, retain and support our health care workers.

Based on a review of reports, studies and other data sources from leading organizations and researchers, this scan provides an annual snapshot of America's health care employment, plus workforce insights and information to guide your organization forward during a time of continued transformation — in our health care environment and our society at large.

To help hospitals and health systems navigate both familiar and emerging workforce-related challenges, the AHA has designed a road map focused on achieving the following goals::

- **Resilience:** Reestablish a robust health care workforce to promote well-being, mental health and resilient staffing.
- **Workforce flexibility:** Develop a well-trained, interprofessional and flexible workforce with both the skills and receptivity for technology and data to match the current and future pace of health care innovation.
- **Capacity:** Increase workforce capacity through a pipeline of talent, so that hospitals can hire, retain and foster provider growth while supporting health in their communities.
- **Strategy:** Support decisions by hospital and health system leaders to prioritize and include the workforce in their organizations' strategic plans.

Health care is about human connection — people taking care of people. The people of America's hospitals and health systems do this each and every day, and the COVID-19 pandemic has shone a spotlight on the vital role they play in our nation's health and safety.

Rod Hochman, M.D.
AHA Board Chair

Rick Pollack
AHA President and CEO

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Today's Insights for Tomorrow's Success

A glance at our key findings:

Reining in the rampant burnout risk requires addressing challenging complexities inherent in our current health care system as well as providing ongoing, tangible, comprehensive support.

Fundamental shifts in delivery models, including widespread telemedicine adoption, will require examining and rethinking multiple components of care, ranging from workflows to patient interactions to educating future clinicians and retraining current ones.

Health care organizations need to help health care workers process the trauma, grief and stress related to the pandemic experience while also focusing on strengthening institutional resilience.

In the new environment, health care must be a "team sport" that features cross-disciplinary collaboration, shared responsibility and effective communication.

Diversity, equity and inclusion initiatives in clinical education, recruitment and retention go hand in hand with proactively reducing disparities in health care delivery and patient outcomes, and increasing interprofessional collaboration on care teams.

Health Care Redefined

The trends that are transforming health care also will have a significant impact on workforce planning. Here are some trends to keep top of mind:

Hospitals and health care systems continue to struggle with economic stability.[1, 2]

While there are signs of economic recovery, hospital finances remain under tremendous pressure, and reestablishing economic sustainability will be a long-term process.

The pandemic severely strained hospitals financially for several reasons, including the astronomical costs of preparing for and treating COVID-19 patients, additional expenses resulting from supply chain and labor market disruptions, and the forced shutdown/slowdown of nonemergent care. After facing catastrophic losses in 2020, our nation's hospitals, health systems and caregivers continue to be severely tested by the COVID-19 pandemic. An analysis conducted by Kaufman, Hall & Associates, LLC for the AHA showed that higher expenses for labor, drugs and supplies as well as patients putting off care during the COVID-19 pandemic continued to negatively impact the financial health of hospitals and health systems throughout 2021. The report projected that hospitals nationwide will lose an estimated $54 billion in net income over the course of the year, even after taking into account federal Coronavirus Aid, Relief, and Economic Security (CARES) Act funding from 2020. The analysis also found that: higher costs of caring for sicker patients and fewer outpatient visits than pre-pandemic levels could lead median hospital margins to be 11% below pre-pandemic levels by year's end; more than a third of hospitals are expected to end 2021 with negative margins; and if there were no relief funds from the federal government, losses in net income would be as high as $92 billion.

The future of behavioral health will look markedly different from its past.[3]

While the pandemic accentuated the need for more — and better — access to behavioral health services across all socio-economic sectors, it also caused significant and positive disruption to the field. Hospitals and health systems quickly scaled remote care platforms to improve access to behavioral health and encouraged employees to seek help when needed, and public and private insurers changed remote care reimbursement policies, paying for services previously denied.

Moving forward, scientific advancements and understanding of the brain, as well as, cultural changes likely will lessen the stigma associated with behavioral health. At the same time, increased access to utilization data for behavioral health services, combined with the use of artificial intelligence will increase the ability to predict the likelihood of mental illness or addiction and offer preventive measures.

The Mental Health Parity and Addiction Equity Act of 2008 needs to be fully implemented and discriminatory practices in public plans such as Medicare's 190 lifetime limit, and Medicaid's Institute for Mental Disease Exclusion should be eliminated. Hospitals have the opportunity to work more closely with community based behavioral health providers and other community partners to create a robust continuum of care through collaboration. Additionally, hospitals and health systems can lead efforts to integrate behavioral health better into all care across the continuum.

Diversity, equity and inclusion starts at the top.[4, 5, 6]

The continuing social and civil unrest has put racial injustice squarely in the spotlight. It also has amplified health care disparities resulting from structural inequities, accentuating the obligation of hospitals and their governing boards to ensure that the health needs of all populations within their community are equitably served and represented. To make that happen, health care organizations need to ensure that their governing boards, C-suites and workforce include a diversity of race, ethnicity, age, gender, sexual orientation, skill sets, thought and abilities.

Ninety-six percent of hospitals report a commitment to fostering diversity and inclusion strategies within their organizations, and 45% say they already have a comprehensive plan for doing so. Health systems report the highest level of diverse representation (17%) on their boards, compared with system subsidiaries (13%) and free-standing hospitals (9%). Forty percent of hospitals also indicate that they have either implemented or achieved an increase in C-suite diversity.

To help health care organizations accelerate efforts to develop effective leadership diversity strategies, the AHA offers numerous tools and resources through Trustee Services and the Institute for Diversity and Health Equity.

Technology will play a pivotal role in new care models. [7, 8, 9]

COVID-19 has driven massive numbers of consumers to try telehealth — and they liked it, a lot. Plenty of providers did, too. Pre-pandemic, the annual revenues of U.S. telehealth leaders totaled about $3 billion. McKinsey & Company predicts as much as $250 billion of current U.S. health care spending potentially could be virtualized, including 35% of home health visits and 24% of office visit/outpatient encounters. Hospital-at-home models that deliver acute, hospital-level care through a combination of telemedicine, remote patient monitoring and in-person visits also are gaining traction.

Capitalizing on the potential of virtual health to transform care delivery and expand access to clinical expertise to wherever patients are requires organizations to prioritize clinician training, support seamless and high-quality interaction by integrating automation and technology, and reassessing existing virtual health programs to scale them appropriately for long-term success.

Focus: Clinician Well-being

Concern about clinician well-being has been top of mind for years, but the pandemic has exacerbated stress and trauma and presented a unique opportunity to reframe core approaches to fostering a thriving workforce. More than ever, clinicians require compassionate, holistic support to ensure that they feel safe, valued and engaged.

Understand the Need

Front-line clinicians are at risk of long-term harm.[10]

The pandemic has intensified the physical and psychological impacts of chronic clinician workforce stressors, threatening long-term well-being. These stressors include:

- **Moral stress:** Balancing duty to society with personal health risks and the need to allocate scarce resources.
- **New roles:** Staffing gaps led to deployment outside typical areas of practice.
- **Disruptions to work networks:** Quarantine requirements separated clinicians from peer-support systems and increased feelings of isolation.
- **Accumulated COVID-19 stress:** Navigating child care, family issues and shelter-in-place challenges amplified occupation-specific challenges. What other local, regional and state resources can you leverage, such as partnering with other hospitals or coordinating volunteer teams, to meet surge-capacity needs?
- **Moral injury:** Consequences of experiencing assault on professional values and commitments, including feeling powerless to save patients.

Coping with a barrage of emotional health challenges takes time and compassion.[11, 12, 13, 14]

The 18 months of fighting COVID-19 have been traumatic and grief-filled for clinicians, who treated vast numbers of critically ill and dying patients, experienced political and racial turmoil, and mourned such

personal losses as the inability to be with family and celebrate milestone events. While most people who experience trauma recover within 12 weeks, a small percentage experience PTSD. Leaders should be aware of the symptoms of persistent trauma — a decline in performance, increased irritability or incivility or poor self-grooming — and provide support to aid in their recovery. Compassionate understanding, ample time and supportive services all play key roles in helping clinicians process trauma and grief so that they can move forward with energy and confidence.

Nurse well-being has escalated from chronic concern to an acute issue.[15, 16]

Worry about nurses' emotional health rose right along with COVID-19 patient numbers. By February 2021, 67% of nurse leaders named mental health and well-being among their top three challenges, up 17% from July 2020. More than one-third named low morale and burnout as the No. 1 challenge that they hadn't faced in the six months prior. Alarmingly, one in four nurse managers also indicated that they were not emotionally healthy themselves. Also, a recent study published in JAMA Psychiatry suggests that in the U.S., the risk of suicide is significantly higher for nurses compared with that of the general population, further underscoring the urgent need to assess and address well-being.

COVID-19-related stress is only one factor among many.[17, 18]

Stress is nothing new for physicians, with 42% reporting that they felt burned out during 2020. Only 8% of doctors cited treating COVID-19 patients as the primary cause of their burnout. Bigger factors included excessive bureaucratic demands (58%), working too many hours (37%) and lack of respect from administrators/employers and colleagues or staff. However, one in five said their burnout emerged only last year and, not surprisingly, specialists in critical care, rheumatology and infectious disease for the first time ranked among the most stressed.

Female clinicians face more pressure, more distress.[19, 20, 21]

Over the years, more female physicians consistently have reported burnout, compared to their male counterparts, but the disparity was greater than usual during the pandemic, and women also exhibited more symptoms of moderate-to-severe secondary traumatization. Typically, women do more heavy lifting than men when it comes to home and family responsibilities, and COVID-19 intensified those pressures with the lack of child care and the need for home schooling. Reducing these burdens requires providers to rethink and expand available support.

Tear down barriers preventing physicians from accessing mental health services.[22, 23]

Front-line clinicians often are unable or unwilling to get help when they need it. A year into the pandemic, only 13% of health care workers said they received mental health services. Another 20% said they thought they needed them but didn't receive them, either because they were too busy, unable to get time off work, couldn't afford them or felt afraid or embarrassed. Physicians typically have been reluctant to seek help, fearing that colleagues or employers will see them as weak or unfit to practice, or that it will jeopardize their licensure status. To reduce this cultural stigma, health care organizations, state medical boards, educational institutions and other stakeholders should examine their policies, regulations, support and expectations. It is vital to reassure clinicians that it is not only normal, but expected and acceptable, to feel overwhelmed at times and to seek help as needed.

Youngest front-line workers have been hardest hit.[24]

Three-quarters of health care workers younger than 30 reported that pandemic-related worry or stress negatively affected their mental health, and seven in 10 reported feeling burned out. Six in 10 worked

directly with COVID-19 patients and 13% had at least 10 patients in their direct care who died from COVID-19. They also said they had to work more hours or work harder because of the pandemic.

When clinicians suffer, patients often do, too.[25, 26]

Addressing clinician stress is critical to consistently delivering high-quality patient care. One-third of physicians who reported depression said they were more easily exasperated with patients, nearly one-quarter were less careful when taking patient notes and 15% blamed burnout for errors they would not have made otherwise.

Workplace violence adds to clinician stress.[27, 28, 29]

Health care workers are five times more likely to experience workplace violence than all other workers. Almost half of emergency physicians who were assaulted six or more times in the past year had been assaulted several times each month. Nearly 55% of emergency nurses reported physical violence and/or verbal abuse during a seven-day period. Whether hurt by threats, harassment, verbal abuse — including from professional colleagues or supervisors — or physical assaults, the resulting injuries and trauma can cause burnout, decrease job satisfaction, increase turnover and affect the quality of patient care.

Rethink Innovatively, Act Intentionally

Normalize help-seeking behavior.[30, 31]

Cheers for front-line clinicians are great, but concrete benefits are even better. Provide insurance coverage and access to independent mental health providers trained in trauma-informed care to help remove the stigma and barriers to using mental health services when needed. Reinforce that seeking help indicates strength, not weakness.

Nurture resilience through trauma-informed leadership.[32]

The Substance Abuse and Mental Health Services Administration (SAMHSA) describes a trauma-informed approach as facilitating healing through the development of interventions specifically designed to address the consequences of trauma. Trauma-informed leadership can help clinical leaders empathize with and support staff traumatized by COVID-19 or other causes. By recognizing and honoring clinicians' emotional scars, leaders can help them process the experience, grow from it and emerge more resilient.

Provide psychological as well as physical PPE.[33]

Psychological personal protective equipment (PPE) comprises the practices and routines that protect and nurture clinician resilience. These could include taking a day off, seeking mental health support or reframing negative experiences. Clinicians can tailor the psychological PPE to their individual needs and regularly integrate it into their work with the support of their leaders and organizations.

Build organizational well-being.[34, 35, 36]

Focus on moving beyond simply eliminating stressors to creating a culture that promotes thriving by taking these steps:

- Develop well-being infrastructure, which could include adapting benefits and expanding

or creating new roles, such as a chief wellness officer.

- Rebuild trust and boost engagement by communicating transparently, practicing active listening, and soliciting and acting on input.
- Make sure that leaders model rest-and-recuperation strategies, essential for sustaining high performance.
- Sustain and supplement existing well-being programs, but also implement pilots to build buy-in and momentum for new initiatives.
- Measure, track and be accountable for well-being outcomes.
- Take advantage of the resources in AHA's Well-Being Playbook.

Empower clinicians to advocate for themselves.[37, 38]

Encourage clinicians to speak up about stressors they face and concerns about either their own health or that of their patients. Strengthen protections for reporting concerns without retribution, such as providing anonymous-reporting mechanisms. Ensure that your leadership responds transparently and proactively to issues raised. Provide both formal and informal opportunities for ongoing peer support.

Adopt a zero-tolerance policy for lateral violence and bullying.[39]

To reduce overt and passive aggressive behavior among clinicians, send a clear, consistent message to all staff that no violence of any type will be tolerated. Take all threats or incidents of violence seriously, regardless of the aggressor's title or position. Explore proactive strategies to decrease incivility and promote teamwork.

Combat workplace violence.[40, 41]

Hospitals can decrease the incidence, likelihood and impact of workplace violence by:

- Developing a workplace violence-prevention program.
- Creating a thorough post-incident debrief and providing counseling.
- Promoting training, education and resources to address the prevention, recognition, response and reporting of workplace violence, including de-escalation, intervention and response to emergency incidents.
- Clearly outlining the roles and responsibilities of leadership, clinical staff, security personnel and external law enforcement when caring for those with histories of violence.
- Building collaborative partnerships with security leadership to mitigate risk and advance the implementation of security measures.
- Empowering clinicians to practice empathetically.

Invest in innovative support initiatives.[42]

Hospitals and health systems across the country have supported their health care teams during the pandemic and beyond, often partnering in myriad ways with local universities or mental health organizations. These range from providing peer-to-peer support groups, chat and text lines, and Lavender Carts to chair massages, virtual yoga, mindfulness classes and Compassion Resilience Toolkits with discussion materials, blogs and video clips. See what else your peers are doing.

Promote self-care with virtual coping techniques.[43]

At University of Louisville Health-Peace Hospital in Kentucky, health care professionals offer coping techniques multiple times a week via Zoom. Trauma Tapping Technique is a proven self-help technique for relieving emotional stress by tapping gently on points of the body, and Havening is an alternative therapy technique that incorporates distraction, touch and eye movements to reduce anxiety associated with negative memories.

Develop well-being champions.[44]

At Northwestern Medicine in Chicago, an innovative Scholars of Wellness (SOW) program has helped advance physician well-being during and beyond the pandemic. SOW's objective is to create a critical mass of wellness leaders — SOW Scholars — to drive meaningful change. Scholars participate in biweekly one-hour sessions during working hours, receive 5% protected time to attend and lead wellness projects, and work with a wellness mentor and coach. Sixty percent of the inaugural class of participants reported decreased levels of burnout and feeling more appreciated in their roles.

Cultivate joy.[45]

Positive emotions have been associated with better job performance and lower burnout, absenteeism and turnover. Recognizing that cultivating joy is a shared responsibility among the organization, department, leaders and individuals, Mayo Clinic's radiology department convened an employee group that developed strategies around workload, efficiency, staff flexibility/control, work-life integration and meaning in work.

Considerations for the Future

- What are your clinical teams' biggest barriers to improving well-being and resilience?
- What strategies do you use to identify clinicians in need of help and to encourage them to access available support services?
- What steps can you take to generate trust and positivity in your team, while still honoring loss and acknowledging grief?
- What leadership qualities are the most critical for supporting clinicians, and how are you developing them?
- Do you offer a comprehensive mix of immediate and long-term support services to clinicians?
- How can you better integrate efforts to help clinicians thrive in your existing culture?

Focus: Education, Training and the Evolving Practice Landscape

The "new normal" in health care requires rethinking clinician education and training for everyone from students to leaders. The pandemic continues to interrupt and disrupt the education of clinicians in training. At the same time, it fundamentally shifted how care likely will be delivered in the future, which has myriad implications for training, retraining and upskilling current and future clinicians.

Understand the Need

Rx for "pandemic interruptus." [46, 47]

Health care organizations are faced with the need to revamp and ramp up training and onboarding for new clinicians. Seven of 10 nurses said the pandemic has affected their ability to onboard new hires and 63% said that they had to extend the orientation timeline. Many recent graduates had gaps in their clinical experience when the pandemic forced health profession schools to suspend or limit in-person clinical instruction. Instead, training often leaned heavily on virtual/simulation or nonbedside areas like quality improvement.

Team-centered approaches continue to gather steam.[48]

Staffing shortages during the pandemic frequently have required rethinking how clinicians are deployed and work as a team within intensive care units (ICUs) and other departments. As health care organizations also focus more on preventive care and well-being, they rely on interprofessional teams to play a larger role inside hospitals and in the broader community. To optimize team performance, especially in high-stress situations, it is vital to ensure that clinicians have excellent collaboration and communication skills, a clear understanding of roles and responsibilities and shared resilience along with the requisite clinical knowledge.

Telemedicine goes mainstream.[49, 50, 51, 52]

Telemedicine's popularity skyrocketed with patients who were unable or unwilling to see physicians because of COVID-19. We have to know how to manage those skills and appropriately train the next generation to have these skills. Eighty-five percent of physicians believe training to improve skills like conveying empathy during virtual visits is essential but lacking in their practices. Nurses also are getting on board — more than 40% of front-line nurses delivered care virtually within the last year, and about two-thirds are interested in providing it in the future.

New nurse graduates face elevated turnover risk.[53, 54]

The turnover rate for new nurse graduates is 35%, slightly less than twice the average nurse turnover rate. Factors include poor understanding of practice expectations, insufficient real-life clinical experience, a highly complex and challenging care environment, lack of support on the nurse's unit and feeling overworked and lost. Despite good intentions and spending an estimated $24,000 to onboard each nurse, hospital education departments often offer ineffective, overly broad orientation programs coupled with insufficient assessment and feedback to support nurses throughout their career journey.

Virtual learning presents real challenges.[55, 56]

Virtual training for clinicians is becoming more widespread, but many educational institutions and health care organizations lack the necessary technology infrastructure to shift efficiently and quickly from classroom or in-person instruction. Drawbacks include technical challenges, the difficulty of engaging students and the inability to conduct one-on-one discussions or provide immediate feedback. Redeploying nurse educators to meet increased staffing needs, as has happened during the pandemic, exacerbates the challenge for nurses.

Critical thinking skills take on new urgency for physician residents.[57]

The sheer quantity of medical literature and fast pace of medical advances means that tomorrow's physicians will need to cultivate the ability to assimilate new knowledge through critical-thinking skills, rather than rely as heavily on their residency training or personal experience. Physician training and ongoing education also must adapt to the learning styles of millennials by incorporating more group-based projects, informal teaching sessions (rather than traditional lectures) and an increased emphasis on why new information is relevant.

New flexibility and new needs demand new skills.[58]

During the pandemic, more than 60% of nurses floated across units, acuity levels and settings — nearly twice the previous rate. About one-third are interested in continuing to do so, indicating the value of cross-training. One-third of front-line nurses also expressed concern that they do not have the skills they need for future success in a role that is evolving quickly. They expect their employers to clarify clinical guidelines for new delivery care models and technology requirements, as well as to provide access to the necessary training.

Rethink Innovatively, Act Intentionally

Reap the benefits of team-based nursing.[59]

Advocate Aurora Health, which serves Illinois and Wisconsin, deploys nursing teams that include a charge registered nurse (RN), primary RNs and support RNs or nursing assistants. This approach allows all

team members to work at the top of their practices, to share responsibility, and to flex and work safely in any environment appropriate for their skill sets. Benefits have included decreased burnout, increased confidence in nursing skills, increased cross-disciplinary collaboration and increased patient satisfaction.

Boost flexibility with multiple staffing models.[60, 61]

Optimize your nursing resources by using a variety of staffing models, depending on experience, availability and complexity of patient care needs. Options include:

- **Team-based staffing:** One RN supervises a team of licensed practical nurses, aides and other support staff caring for a group of patients.
- **Tiered staffing:** Recommended by the Society of Critical Care Medicine to augment experienced ICU staff by incorporating non-ICU-trained staff of all disciplines.
- **Primary nursing care:** A single nurse serves as primary caregiver for a shift/encounter, supervising ancillary staff involved in the care of the patient.
- **Functional care delivery:** The nurse manager coordinates care by delegating tasks through a hierarchical structure.

Manage teams skillfully and thoughtfully.[62]

Pandemic or not, several factors can affect team performance in high-stress clinical settings. These include overwork, fatigue, unfamiliar new team members and scarce resources. By knowledgeably anticipating and actively addressing these risk points, leaders can help teams coordinate effectively, increase resilience, improve each team member's ability to discuss concerns forthrightly and support high-quality patient care.

Build professional as well as clinical skills.[63]

Interpersonal communication, delegation, evidence-based practice, leadership and other professional skills often challenge newly minted clinicians more than clinical proficiency. It is critical to explore innovative ways to supplement teaching these skills, including creating engaging and immersive experiences through videoconferencing and virtual education.

Support diverse learning styles — in person and virtually.[64]

As education and training increasingly become hybrids of virtual and in-person opportunities, plan strategically to ensure consistency across your organization. No matter which platform is used, ensure that your curriculum meets the needs of clinicians with diverse learning styles. The opportunity for open dialogue between new health care professionals and their support teams is also a crucial component, enabling immediate feedback, clarification of questions or issues, and follow-up on progress or concerns.

Be creative with nurse orientation and continuing education.[65, 66]

Incorporate a wide spectrum of teaching strategies that more effectively engage new clinicians as well as improve patient outcomes. Relying less exclusively on lectures and incorporating innovative opportunities such as a flipped classroom model, microlearning simulation labs, virtual reality and video games ultimately can improve job satisfaction, lower retention rates and improve quality of care. Integrating assessment tools that identify specialty-specific knowledge gaps also can decrease the time and cost of education and effectively meet individual learning needs.

Nurture workforce management agility.[67]

Create a workforce management infrastructure that supports staff needs in normal times while also enhancing their ability to perform well in times of crisis. This includes making leaders accountable for ensuring that staff have appropriate skill sets, committing to cross-training staff and creating centralized nurse resource pools that provide flexibility for redeploying staff.

Support development of "webside" manner.[68, 69, 70]

Even though the newest generation of clinicians are digital natives, they need experiential opportunities to polish their telehealth communication skills with patients. New and existing physicians and nurses will need training on how to integrate new digital tools into their practices, strategies for minimizing digital fatigue and guidance on communicating clearly and empathically virtually. Training both physicians and patients to use remote monitoring tools and integrating them with electronic health records and other technologies are also vital to the success of telehealth.

Improve clinical education equity and accessibility.[71]

The pandemic continues to heighten the awareness of inequities in resources and student experiences in nursing and academic medicine, underscoring the need to intentionally rethink clinical training, education and workforce organization to improve and support diversity. This includes taking steps to improve the affordability of clinical education, address inequities created by the inconsistent opportunity to visit clinical rotations during the medical residency-selection process, and developing systems for assessing progress toward diversity, equity and inclusion.

Considerations for the Future

- How effective are the engagement and support tools you use to transition new nurses from the academic environment to clinical practice?
- What steps are you taking to personalize learning opportunities for your recent nurse graduates?
- What types of self-service, on-demand learning tools are available to your team members when they want to reinforce and strengthen their knowledge?
- What COVID-19-caused training gaps have you identified in new clinicians, and what strategies have you developed to bridge them?
- How have you expanded your training to assist physicians in adapting their bedside manner to telehealth, demonstrating empathy during virtual visits and improving practice revenue through a hybrid care delivery model?
- What steps are you taking to help clinicians cultivate the skills needed to work effectively as team members?

Focus: Keeping Pace with Future Demand

Growing a robust workforce capable of providing accessible, equitable, high-quality patient care demands a multifaceted approach. Recruitment and retention must continue to be top priorities to ensure highly qualified, flexible and committed clinicians who are passionate about the health and well-being of all patients.

Understand the Need

Physician workforce volatility.[72, 73]

By the latter part of 2020, about 8% — around 16,000 — physician practices had closed because of the pandemic, and an additional 4% planned to close within the next 12 months. About 16% of physicians anticipated changing their practice patterns within the next year, whether moving to new employment or practice, no longer treating patients or working only on temporary assignments. Among employed physicians, half said they planned to switch employers, 21% said they would retire early and 15% decided to quit medicine.

More pandemic upheaval.[74]

More than 22% of nurses indicated they were considering leaving their current position within the year, with 60% of those saying they were more likely to do so since the pandemic. The top three driving factors were insufficient staffing, workload intensity and emotional toll. More than half planning to leave said they were looking at another career path, wanted to stop providing direct patient care, planned to retire or leave the workforce entirely. On the other hand, 17% of nurses reported that the pandemic increased their desire to stay in the profession.

The "Fauci Effect" bumps up interest.[75]

In 2020, applications to medical schools also jumped 18% and enrollment in bachelor of science in nursing (BSN) degree programs increased nearly 6%. Two-year associate degree programs in nursing also appear to be following suit. However, tens of thousands of qualified applicants are turned away annually due to a shortage of faculty, clinical training sites and classroom space. More than 222,000 nurses took the National Council Licensure Examination last year, an increase of 5%, indicating that some people who earned nursing degrees but haven't been practicing are having a change of heart.

Nursing vacancies, turnover and costs are up.[76, 77]

Seventy percent of hospital executives reported losing from 5% to 30% of their nursing staff due to the pandemic, in most cases losing at least some to high-paying travel assignments. More than a third anticipated having more than 25 nurse openings this year, up from 17% in 2020, while 21% said they would have more than 50 vacancies and 11% predicted more than 100. More than 80% of chief nursing officers and chief human resources officers (CHROs) have seen an increase in permanent nurse turnover during the pandemic. Record demand for travel nurses drove up the average annual salary to $122,000, from $112,000, by year-end 2020, and signing bonuses increased 12% to $9,190, from $8,200.

Rosy outlook for health care employment.[78, 79]

Across the board, the U.S. economy shed millions of jobs during the pandemic. Although health care still numbers 500,000 jobs below pre-pandemic levels, the Bureau of Labor Statistics projects that about 2.4 million new jobs will be added by 2029, faster than average for all occupations and similar to pre-pandemic estimates. The growing complexity of patient needs also will require broadening the scope of practice for many health care professionals as well as increasing demand for specialists in primary care, long-term care, behavioral health, and public and community health.

Hiring diversity still lags.[80]

The disproportionate impact of COVID-19 on communities of color highlighted health care's racial and socio-economic inequities, which are amplified by the lack of diversity among physicians and surgeons, nearly 65% of whom are white. Less than 6% are Black and only .75% are Latino, even though Blacks comprise more than 11% of the U.S. population and Latinos close to 5%.

Rethink Innovatively, Act Intentionally

Reenvision rather than simply rebuild.[81, 82]

While the pandemic has spotlighted many factors that are pushing nurses away from the workforce, it also sheds light on what they value most about the work they do. The disruption and chaos have created a unique opportunity to fundamentally reevaluate how to deliver care and manage workforces, incorporate new learnings and workforce aspirations, and reframe the path forward.

Recognize that retention strategies are not one-size-fits-all.[83, 84, 85, 86]

Boost retention by listening to what clinicians want and need, and tailoring solutions appropriately:

- While all nurses seek appropriate and sufficient recognition and compensation for expertise and effort, some may put a premium on other factors including flexible scheduling, strong management support, open lines of communication, input into decision-making, or help with child or eldercare.
- Surveys of employed physicians indicate that increased pay, additional time off, reduced on-call

and paid sabbaticals are key retention factors. But other factors that can boost satisfaction include increased autonomy, more face time with key leaders and more formal recognition for job performance.

Lean more on advanced practice nurses.[87, 88]

Licensed nurse practitioners (NPs) took on greater responsibility during the pandemic when many state executive orders granted them larger roles, given the pressing need for primary care professionals. Their role will continue to grow along with value-based care models. Their ranks are also expanding, increasing 12% in the last year to a record 325,000-plus. Nationwide, more effective use of NPs and physician assistants could have the same impact as adding 44,000 new primary care physicians.

Strive to become a preferred millennial/Gen Z destination.[89]

As workforce shortages continue, new clinicians can be selective about where they work and for what kind of organization. Offering millennials the ability to tailor their schedules to allow time for innovation, or creating a career lattice that enables them to move in many directions within your organization can be appealing. Sharing your mission, values and diversity, equity and inclusion (DEI) goals can be critical to Gen Z employees who often value culture fit over traditional benefits.

Diversify and strengthen diversity recruiting.[90]

Review and expand your talent sources to ensure that you're tapping into diverse school populations, networks and events that reach diverse candidate pools:

- Leverage social media as part of your recruiting channel mix.
- Make sure you get the word out about your DEI commitment by publicizing the right content to the right audiences.
- Encourage diverse leaders in your organization to share their stories.
- Walk in the shoes of a diverse job seeker and take an honest inventory of your candidate's experience to weed out racial, gender and other conscious or unconscious bias.

Urge congress to prioritize funding support.

At the federal level, the AHA is urging Congress to pass bills to address clinician shortages and bolster the health care workforce, including:

- Resident Physician Shortage Reduction Act of 2021 (S.834/H.R. 2256), which would add 14,000 Medicare-funded residency slots.
- Dr. Lorna Breen Health Care Provider Protection Act (S.610/H.R. 1667), which aims to prevent suicide, burnout and behavioral health disorders among health care professionals.
- Healthcare Workforce Resilience Act (S.1024/H.R. 2255), which would expedite the visa authorization process for qualified international nurses.
- Future Advancement of Academic Nursing Act (S.246/H.R 851), which would support nursing education and provide resources to boost student and faculty populations, as well as support educational programming, partnerships and research at schools of nursing.

Advocate for state legislative support.

Creative state-level strategies, often in partnership with state hospital associations, community colleges or health professional organizations, can help fill the RN pipeline.

- With state funding, the New Mexico Nursing Education Consortium expanded a common pre-licensure BSN degree curriculum. It is now offered in 16 locations throughout the state, with a BSN degree also offered in most.
- In South Carolina, legislation soon may allow students to pursue a health profession career via the technical college system at virtually no cost.
- In Tennessee, legislation may streamline onboarding by allowing nursing graduates to practice under the supervision of a licensed RN while awaiting testing and licensure.

Recruit outside the lines.

Expand your recruiting efforts beyond your state lines, capitalizing on your ability — and the increased expectation of candidates — to connect and interview via virtual platforms. Also consider proactively recruiting candidates who are disillusioned with or laid off from other industries and are now seeking to make a career shift, especially to a mission-driven field like health care.

Integrate workforce planning with strategic planning.

As the health care landscape is transformed by such key forces as the societal factors that impact health, emerging technologies and consumerism, deepen your understanding of the impact on the workforce, the nature of the jobs clinicians perform and how to help clinicians prepare for and embrace change.

Considerations for the Future

- Are you reimagining delivery models to boost nurse satisfaction, such as expanding use of telemedicine platforms that allow nurses to work remotely more often?
- Do you foster nurse engagement and retention by regularly soliciting and acting on their input through structurally embedded opportunities like shared councils and committees?
- Are you taking a multipronged approach to hiring diverse talent at all junctures of the career journey, from students to seasoned medical professionals?
- Have you reviewed and updated your succession planning strategies for clinicians?
- What technologies are you exploring to help you optimize clinical workforce productivity and ensure patient access to health care when clinician numbers are limited?
- What gaps do you have to address so that you can quickly and efficiently ramp up, deploy and support staff during the next emergency or pandemic?

Health Care Talent Scan
Ask the Experts

Diversity in the workforce is just one piece to closing care disparities. How can health care senior leaders escalate the recruitment of diverse clinicians and nonclinicians alike and nurture a supportive culture that strengthens retention?

JOY A. LEWIS
Senior vice president, health equity strategies; executive director, Institute for Diversity and Health Equity, American Hospital Association

Ensuring that the workforce reflects the diversity of the community that a hospital serves is a critical factor toward building trust between patients and providers. The data are indisputable; having a diverse set of perspectives leads to better decisions, which leads to better care. It is one thing to recruit individuals who possess diverse characteristics into a work environment, and it is another level of effort to include and embrace them as team members who bring value.

For diverse, talented candidates to thrive in the workplace, there has to be a culture and a set of organizational priorities that require human resources leaders and other senior leaders to be intentional about investing in the necessary support to retain and position these individuals for successful careers. These include mentoring, executive sponsorship, coaching and employee resource groups. It is also important to move from one or two individuals who bring diversity (tokenism) to a sizable number, and that will only occur through targeted efforts. For example, for every open position in the hospital/health system, there should be a diverse slate of candidates under consideration. In addition, there has to be equal opportunity for diverse leaders to have their voices heard at the table. Far too often, leaders are recruited based upon their diverse and inclusive attributes, but the organizational culture does not lend them an opportunity to voice their opinions on all topics, especially those that span outside of diversity and inclusion.

Culture shifts do not happen overnight. So, be relentless in the pursuit of a diverse, equitable and inclusive work environment. I cannot overstate how important diversity and representation is for driving better organizational decision-making and improved patient outcomes.

How will the training of incoming nurses and physicians need to change to prepare them for managing during a pandemic or other crisis? Have you heard of any interesting partnerships to help in this area?

ROBYN BEGLEY, R.N
Senior vice president & chief nursing officer, American Hospital Association; CEO, American Organization for Nursing Leadership

One of the early lessons learned from the COVID-19 pandemic was the importance of cross-training nurses and physicians to work outside of their specialties to cover care needs, regardless of the department or care setting. Additionally, new models of care emerged utilizing interprofessional teams. It is critical that we incorporate these lessons learned in nursing and medical education curricula and clinical training.

After convening a cross-section of health leaders in academia, practice and regulation, the Tri-Council for Nursing issued its report "Transforming Together: Implications and Opportunities from the COVID-19 Pandemic for Nursing Education, Practice, and Regulation," identifying lessons learned and opportunities to transform the future of health care. Under the recommendation for rapidly mobilizing health care to respond to future emergencies, the report calls for educational resources to support disaster response and competencies, as well as robust national models for mobilizing and cross-training resources.

Building a culture of safety and prevention is essential to preparing health care workers and organizations for future emergencies. The Centers for Disease Control and Prevention developed a collaborative with the AHA and a diverse group of other health organizations to create Project Firstline, a national training program that takes an interprofessional approach to infection control. Through Project Firstline, the AHA offers hospitals and health systems the tools and resources needed to engage all stakeholders — from bedside nurses to administrators and environmental staff — to identify areas of improvement, commit to an action plan, monitor practices and adjust as needed.

PATRICE M. WEISS MD, FACOG
Chief medical officer- executive VP, Carilion Clinic; professor of OB/GYN, Virginia Tech Carilion School of Medicine

COVID-19 forced hospitals, health systems and their clinicians to rapidly adapt practices and care for communities in new ways. Team models that allowed all practitioners to work at the top of their scope and support a larger number of patients were put into place and just-in-time cross-training allowed hospitals to adjust to the quickly evolving aspects of pandemic care.

As we look to train the next generation of clinicians, we must apply core lessons from COVID-19: Increase flexibility and nimbleness while maintaining high-quality care and supporting the well-being of our teams. Core to that is broadening infection-prevention education to allied health professionals and ensuring that clinicians learn the roles of everyone on the health care team, clinical or otherwise, to address infection prevention and control.

What innovative approaches and/or strategies are hospitals or health systems taking in response to the physical and emotional impact that COVID-19 has had on front-line clinicians, particularly their mental health needs?

GAURAVA AGARWAL, M.D.
Associate professor of psychiatry and behavioral sciences and medical education; director of physician well-being, Northwestern Medicine Medical Groups; director of undergraduate medical student education in psychiatry, Northwestern Medicine

Health care workers and community members have faced, and are still facing, challenges as never before due to the COVID-19 pandemic. Initially, we focused on obtaining needed physical PPE to protect the health of clinicians and staff, but equally important then and now is psychological PPE to protect their mental health. Comprehensive resources include providing PPE for primary prevention such as strong leadership and communication as well as stress reduction strategies, secondary prevention resources such as peer support, and tertiary prevention resources including EAP resources and readily accessible therapy and/or medications.

To support this work, the AHA released "AHA Hospitals in Action: Supporting Care Teams," compiling hospitals' and health systems' stories on how they are supporting health care workers' well-being during the COVID-19 pandemic, including the use of "lavender carts," time-out rooms and easily accessible mental health programs. This resource is a companion to the recently updated "Well-being Playbook 2.0," which outlines leadership questions for scaling and sustaining well-being programs.

How can provider organizations develop and support efforts to create a more resilient clinical workforce?

SHARON PAPPAS, PHD, R.N., FAAN
Chief nurse executive, Emory Healthcare

At its core, addressing burnout is about helping care teams recapture the joy and purpose of their work. The goal is not simply an absence of burnout; but to cultivate a culture of well-being so clinicians can provide the best care possible for their patients. COVID-19 has added new complications and urgency to the challenges faced when administrative burden and care that is delivered through a series of disconnected tasks, suboptimal communication systems, and unbalanced teams collide with an extended crisis. In addition, the traumatic impact of the pandemic, in particular on clinicians in hard-hit areas, has amplified the need for support and efforts to improve wellness and well-being. The process will take time, but the journey to a strong sustainable culture begins with a few steps, outlined in the AHA's "Well-Being Playbook":

- Create an infrastructure for well-being.
- Engage your team.
- Measure well-being.
- Design interventions.
- Implement programs and changes.
- Evaluate program impact.
- Create a sustainable culture.

BECKY RAUEN
ASHHRA board vice president; vice president, human resources, North Memorial Health

Organizations need to help caregivers accept or acknowledge their need for support – that it's OK to get help, and that they needn't fear being seen as incompetent. Leaders need education to recognize when their team members are in distress and how they can provide support. Peer-to-peer support programs are also important. Finally, organizations must not only support team members' resilience, but they must also address organizational and operational problems that may impede their work.

EMILY ENDERT
ASHHRA board member; director of human resources, Covenant Woods

Make mental health services available and encourage people to take time off to have some fun. Taking time to be creative and get your mind off work rejuvenates you, so that you are your best when you are on the job.

In what ways will regulatory and policy changes resulting from the pandemic, such as expanded scope of practice for nonphysician practitioners or expanded telehealth reimbursement, affect the workforce?

AKIN DEMEHIN
Director, policy, American Hospital Association

The regulatory flexibilities provided during the pandemic were vital in allowing hospitals and their talented teams to respond quickly to provide access to care in a profoundly challenging and unpredictable environment. However, our members also found that making many of these changes permanent would advance the quality of care and improve the patient experience even beyond the pandemic. The AHA continues to work with its members and policymakers to identify and make permanent the regulatory changes needed to capitalize fully on these important innovations.

Physician and nursing shortages often were discussed before COVID-19. Do we have a sense of how significant the pandemic has been on doctors and nurses who are choosing to leave the field?

MARY ANN FUCHS, R.N.
American Organization for Nursing Leadership board president; vice president of patient care and system chief nurse executive, Duke University Health System

COVID-19 has taken a heavy toll on health care workers who have been on the front lines of the pandemic, with many suffering from trauma, burnout and increased behavioral health challenges. We are concerned about their well-being and are monitoring the number of clinical and administrative nursing leaders and physicians who are considering taking a break from direct patient care or permanently leaving the health care field.

The other issue is that nearly 40% of registered nurses are older than 50. Many put off their planned retirement so they could help their communities fight COVID-19 but, as the pandemic subsides, we likely will see them start to leave. This is also true with clinician leaders. While we do not have the data yet, anecdotally, we know this trend is beginning to occur.

The good news is, according to a new survey from the American Association of Colleges of Nursing, bachelor-degree nursing enrollment increased by 6%. Graduate-level nursing programs also increased in 2020. The downside is that we do not have enough nursing faculty to meet the demand for increased capacity in our colleges. Another challenge is the difficulty in expanding clinical sites for training. Nursing programs denied enrollment to more than 80,000 qualified applicants last year.

What do health care senior leaders need to do now and in the coming years to address clinical workforce needs in their strategic plans?

CHRISTINE GALLERY
Senior vice president planning & chief strategy officer, Emerson Hospital

In many organizations, key strategic plan "pillars" often will include People as a key area of focus, identifying specific goals and objectives for the workforce strategy. Often the CHRO drives strategic planning for workforce which could include objectives

around recruitment, competitive compensation, flexibility for remote work or becoming an employer of choice. Additional strategies for retention and leadership development also might be included, such as implementing focused efforts on leadership education.

What can health care leaders do to cultivate an attractive and supportive environment for millennial and Gen Z clinicians and other vital hospital staff?

BECKY RAUEN
ASHHRA board vice president; vice president, human resources, North Memorial Health

- Encourage a work-life balance with flexible scheduling, remote work when possible and equity in workload and support.
- Provide stretch assignments, growth opportunities and promotions. Allow them to chase their passion.
- Offer a visible career plan — making them part of the decision-making in creating pathways — and a formal succession plan.
- Deliver direct and immediate feedback. Leverage technology to deliver real-time feedback and access to self-service development and answers to their questions.
- Provide both formal and informal opportunities for mentorship and work buddies.

EMILY ENDERT
ASHHRA board member; director of human resources, Covenant Woods

Create an environment in which people are comfortable speaking up and know that they are being heard. This may require a behavior change for managers and training to help them learn to slow down and listen without distractions.

What role will virtual training and on-demand learning tools play in helping to accelerate on-boarding, cross-training and ongoing professional development?

JEREMY SADLIER
Executive director, ASHHRA

Technology is always adapting, and organizations will have to do so as well. The idea of a static or fixed training or learning solution needs to be sunsetted: Don't create your education tools around today — plan your education around constant change and adaptation.

BECKY RAUEN
ASHHRA board vice president; vice president, human resources, North Memorial Health

On-demand training allows for flexibility, but you have to have technology that is easy to use and you may need to provide training. In this environment, we need to interview, select and onboard fast to get the best candidates, and virtual training can help accelerate onboarding. However, you shouldn't have everything virtual — there is a networking and relationship balance that is important to keep.

EMILY ENDERT
ASHHRA board member; director of human resources, Covenant Woods

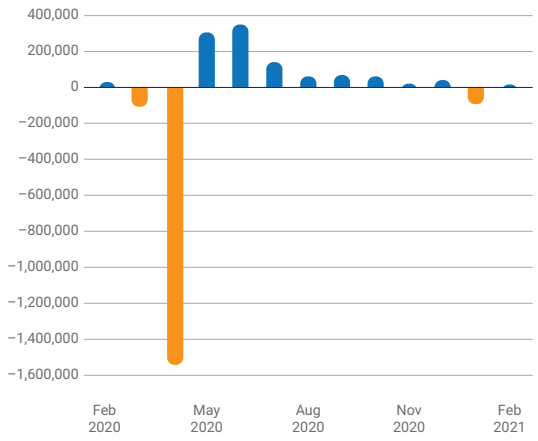
Virtual training is critical for on-demand needs. It will be important to have small bites (10 minutes or less) so that people can learn on the run without feeling bogged down. Also, simple one- or two- click access will encourage them to use the on-demand training options.

By the Numbers

Effects of COVID-19 Pandemic on 2020-2021 Health Care Workforce

Ups and Downs in Job Numbers

- Health care workforce declined 3.5% (from 16.49 million jobs to 15.92 million) between February 2020 and February 2021.[91]
- Hospitals added 31,500 jobs in December 2020, compared with 4,700 job gains in November and 16,200 job gains in October.[92] December's was the largest monthly increase since the beginning of the COVID-19 pandemic, but nearly 70,000 fewer than at the March 2020 peak.[93]
- Hospitals began 2021 with four months of job losses:
  - January — 2,100, the first job loss seen since losing 6,400 jobs in September 2020.[94]
  - February — 2,200[95]
  - March — 600[96]
  - April — 5,800[97]
- In a turnaround, hospitals added 2,900 jobs in May.[98]

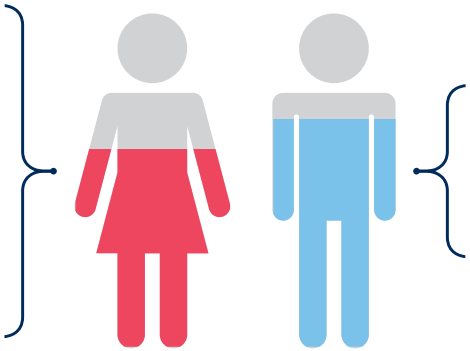


Month-over-month Change in Health Care Employment, Seasonally Adjusted[99]

Health Care Job Declines by Gender: February 2020 to October 2020

Women held 530,000, or 3.8%, fewer 2020 health care jobs in October than in February, likely due to limitations on safe and affordable child care.[100]

200,000 women's jobs were lost in nursing homes, likely due to fewer elective surgeries and subsequent demand for rehab, the toll of COVID-19 on residents and people opting for in-home care.[101]



Men held 36,000, or 1.2%, fewer 2020 health care jobs in October compared with February.[102]

By the Numbers

CONTINUED

Mental Health Issues and Burnout

Physicians' Mental Health During COVID-19[103]

50% experienced inappropriate anger, tearfulness or anxiety.

8% had thoughts of self-harm.

Physician Burnout Increased in 2020[104]

- 42% felt burned out.
- 69% were somewhat or very happy in 2020 before the pandemic started; that fell to 49% during the pandemic.
- 51% of female physicians vs. 36% of male physicans felt burned out, widening the historic gap.
- 51% of critical care physicians felt burned out, the highest rate among all specialties.
- 79% said their burnout began before the pandemic.
- The 3 most common burnout contributing factors: too many bureaucratic tasks, too many hours spent at work and lack of response from leaders or colleagues.

Nurses' Mental Health During COVID-19[105]

- 73% suffered from challenges with sleep.
- 50% felt overwhelmed.
- 30% suffered from challenges with sleep.

Nurse Burnout Increased in 2020

Comparison of High Burnout Levels Pre-Pandemic and 6 Months In[106]

TYPE OF NURSE	VERY BURNED OUT BEFORE PANDEMIC	VERY BURNED OUT 6 MONTHS IN
Registered nurse	4%	18%
Licensed practical nurse	6%	20%
Nurse practitioner	5%	13%
Clinical nurse specialist	3%	12%
Certified registered nurse anesthetist	3%	10%
Nurse midwife	5%	13%

By the Numbers

CONTINUED

Health Care Workforce Overview

Clinician Workforce Shortages

Physician Shortages

- A primary care shortage is projected to be between 21,400 and 55,200 physicians by 2033.[107]
- A large portion of the physician workforce is nearing traditional retirement age.[108]
- The U.S. is projected to experience a shortage of more than 7,900 intensivist physicians during the pandemic.[109]
- In early August 2020, 26 states were at risk for shortages of intensivists.[110]

Nursing Shortages and High Demand

- Demand for registered nurses is expected to grow by 12% (much higher than the average for most professions). 371,500 new RN jobs will be added by 2028.[111]
- Demand for travel nurses to care for COVID-19 patients climbed 239% from September 2020's 12,800 job openings to 30,880 on Jan. 4, 2021.[112]
- Nurse practitioner employment will grow by 52% between 2019 and 2029, likely as a response to the primary care physician shortage.[113]

Trends and Expectations

- More women are becoming physicians: 36.3% of the 2019 physician workforce vs.28.3% in 2007.[114]
- More men are becoming nurses: 2.2% of nurses were male in 1960 vs. 12% in 2019.[115]
- From the current 26 states and territories that grant nurse practitioners full practice authority, more are likely to follow suit based on the pressing need for primary care providers and recommendations by the National Academy of Medicine and National Council of State Boards of Nursing.[116]
- More physicians are specializing in sports medicine: up 55.3% between 2014 and 2019.[117]

6 of the 10 Fastest Growing Occupations Are Related to Health Care[118]

Percentage Growth, Projected 2019-2029

JOB	GROWTH %
#2 Nurse practitioners	52.4%
#5 Occupational therapy assistants	34.5%
#6 Home health & personal care aides	33.7%
#7 Physical therapist assistants	32.6%
#8 Medical & health services managers	31.5%
#9 Physician assistants	31.3%

Resources

www.aha.org/workforce

is the American Hospital Association's hub for workforce-related resources. It includes relevant news, reports and white papers, links to upcoming conferences, and webinars, archives of past events, and case studies and a variety of resources for workforce development.

The AHA has multiple divisions that address workforce issues:

AHA Physician Alliance
(https://www.aha.org/aha-physician-alliance)

American Organization for Nursing Leadership
(https://www.aonl.org)

American Society for Health Care Risk Management
(https://www.ashrm.org)

Institute for Diversity and Health Equity
(https://ifdhe.aha.org)

Association for Healthcare Volunteer Resource Professionals
(https://www.ahvrp.org)

AHA Team Training
(https://www.aha.org/center/performance-improvement/team-training)

Hospitals Against Violence Initiative
(https://www.aha.org/hospitals-against-violence/human-trafficking/workplace-violence)

COVID-19: Stress and Coping Resources
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Charter

Quality Committee
Tahoe Forest Hospital District
Board of Directors

PURPOSE:

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

RESPONSIBILITIES:

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

DUTIES:

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

COMPOSITION:

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

MEETING FREQUENCY:

The Committee shall meet quarterly.

Commented [RM1]: **FROM QA/PI PLAN, AQPI-05:**

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.