CNO Advisory Committee Meeting

Meeting Book

Tuesday, January 21, 2020

California Hospital Association

1215 K Street, Suite 800

Boardroom

Sacramento, CA, 95814

800-882-3610 passcode: 7795222#

Meeting Book - CNO Advisory Committee Meeting

CNO Advisory Committee Meeting Agenda - January 21, 2010

CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

January 21, 2020

TO: CNO Advisory Committee Members

FROM: Dietmar Grellmann, SVP, Policy
BJ Bartleson, MS, RN, NEA-BC, Vice President, Nursing and Clinical Services

SUBJECT: CHA Governance Renewal Task Force Update/ACNL Board Seat

SUMMARY

The Association of California Nurse Leaders, the state's professional organization for Nurse Leaders in California, has shared a productive, collaborative relationship with CHA for the past thirty-eight years. Leaders from both organizations develop consensus on shared policy and advocacy interests to represent hospitals and health systems. Through the years, both organizations have made leadership and governance changes to advance their respective missions in an everchanging environment.

Over the past year, CHA has been exploring changes to the CHA Board of Trustees structure and process to address the following:

- The California hospital field faces significant changes now and for the long term.
- The pace of change is and will continue to be brisk.
- Addressing change will require the association to respond in a rapid and evolving way, involving even greater collaboration and consensus building with others.
- The governance setting needs to support generative thinking for CHA to be bold, nimble, and foster necessary collaboration to create change in a timely manner.

An ad hoc Governance Renewal Task Force, under the direction of the CHA Executive Board and their guiding principles, finalized their report, and proposed CHA Bylaws changes that were approved at the October 24th CHA board meeting. These process and structure changes were based on the guiding principle that governance structure drives optimal function and efficiency, and, should be consistent with best practices for meeting desired objectives. Board members should be selected based on needed attributes and skills. There should be no guaranteed seats. The size should be optimal for discussion and decision making, preferably smaller than the present board, with more consistent board term length to allow board members enough time to build expertise. Members should be at the highest levels in order to commit their organization, and, there should be limited and optimal non-hospital representatives to facilitate more open and candid discussion by board members.

Historically, the ACNL President has had a guaranteed position for the CHA bylaws designated patient care services seat. The CHA board had numerous other specific guaranteed seats that have now been changed per the new bylaws to address appropriate diversity and representation through a nominating

committee process. This will ensure the board is comprised of the best candidates and leaders in the California hospital field, ensuring that individuals who serve on the board are at the highest decision making levels in their organizations and are able to commit their organizations to policy positions and other actions by the board.

DISCUSSION

1. Do these changes make sense considering the projected turbulence in our state and federal healthcare landscape environment?
2. How can the CHA CNO Advisory Committee continue to represent ACNL and Nurse Executive Leadership practice issues to the CHA staff and Board?

ACTION REQUESTED

- *Information sharing and feedback on the aforementioned discussion questions.*

BJB:br

CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

January 21, 2020

TO: CNO Advisory Committee Members

FROM: Dietmar Grellmann, SVP, Policy
BJ Bartleson, MS, RN, NEA-BC, Vice President, Nursing and Clinical Services

SUBJECT: Member Session/Strategy Development

SUMMARY

To align our committee to work more directly with CHA 2020 policy and advocacy priorities, we would like to review the 2020 CHA priorities, and the mission of the CHA CNO committee to develop a specific detailed strategy that includes results-oriented activities and deliverables. In review, CHA seeks to develop consensus and establish public policy and advocacy priorities to serve hospitals and health systems. The present CHA CNO Advisory Committee mission is to advise CHA on key policy and advocacy issues specific to hospital and nurse executive practice. To move to our 2020 goal, we would like to expand upon our present mission to include specific aligned actions that produce deliverables.

The attached power point outlines the 2020 public policy priorities as identified from specific region CEOs, and top policy issues identified by CHA Advocacy and Policy leadership. In summary, policy issues are:

- Seismic
- Behavioral health
- Affordability
    - Coverage for all
    - Equitable access
    - Improving value

DISCUSSION

1. Reviewing the broad policy issues identified above, what specific issues related to nursing practice would you connect to them and why?
2. What issues are you most worried about and why?
3. What are your current priorities?
4. How do your priorities compare with others in the group?

ACTION REQUESTED

- Information sharing and feedback on the discussion questions.

Attachments: Member Policy Priorities
2020 Advocacy Priorities – Summary Report of Member Survey Results
2020 Environmental Scan

BJB:br

What We Heard From You

Importance of Current Priorities Issues – Top Five Highlighted

Statewide Summary	Hospital Council	HASC	HASD&IC
1. Behavioral Health	1. Behavioral Health	1. Behavioral Health	1. Behavioral Health
2. Medi-Cal Reimbursement	2. Medi-Cal Reimbursement	2. Medi-Cal Reimbursement	2. Medi-Cal Reimbursement
3. Medicare Reimbursement	3. Access to Care	3. Medicare Reimbursement	3. Medicare Reimbursement
4. Quality and Patient Safety	4. Quality and Patient Safety	4. Governmental Regulations	4. Access to Care
5. Access to Care	5. Workforce Shortages	5. Quality and Patient Safety	5. Quality and Patient Safety
6. Governmental Regulations	6. Medicare Reimbursement	6. Access to Care	6. Commercially Insured Reimbursement
7. Workforce Shortages	7. Governmental Regulations	7. Commercially Insured Reimbursement	7. Workforce Shortages
8. Commercially Insured Reimbursement	8. Cybersecurity	8. Workforce Shortages	8. Governmental Regulations
9. Cybersecurity	9. Population and Community Health Improvement	9. Other Reimbursement Issues	9. Emergency Department Crowding
10. Emergency Department Crowding	10. Health Outcome Disparities	10. Cybersecurity	10. Cybersecurity

CHA 2020 Advocacy Outlook

What's coming at us in 2020?

Policy

- Surprise medical billing/out-of-network billing
- Affordability (cost containment)
  - Healthy California for All Commission
  - Rate-setting
  - Consolidation
- Independent contractor fix

Politics

- 2020 presidential election
- State elections
- Ballot initiatives

CHA 2020 Advocacy Outlook

Why 2020 will be a landmark year…

- Affordability framework
- Governor's agenda taking shape
- Opportunity to reposition the field

CHA 2020 Advocacy Outlook

What are we for in 2020?

Policy

- Seismic
- Behavioral health
- Affordability
  - Coverage for all
  - Equitable access
  - Improving value

Members were asked for their top concern in each priority policy area and suggestions for revising or strengthening the Associations' focus on each issue. Member comments have been grouped by themes and are summarized below.

1. **Expand Access to Care – TOP CONCERNS**
   A. Equitable Access to Behavioral Health services in the community (particularly for homeless, underserved and low-income populations)
   B. Insufficient Provider Supply (both primary care and specialists)
   C. Inadequate funding for and reimbursement of mental health services to offset cost of care (and an inadequacy of Medi-Cal network and funding)
   D. Need for alternate sites of services (to reduce emergency department overutilization and improve post-acute care access)

   Expand Access to Care – SUGGESTIONS
   A. Keep and expand coverage – including Affordable Care Act, Covered California, Medicare Advantage Medi-Cal expansion
   B. Workforce development initiatives to increase provider supply
   C. Improve community collaborations of care including Long-term care, Skilled Nursing Facilities, Home Health services

2. **Improving Behavioral Health – TOP CONCERNS**
   A. Need for Behavioral Health services (access, capacity, locations) in the community
   B. Need for improved collaborations with community resources
   C. Insufficient behavioral health provider supply
   D. Inadequate funding, reimbursement, adequate insurance coverage

   Improving Behavioral Health – SUGGESTIONS
   A. Fair and equitable funding and reimbursement to cover costs and fund increased capacity initiatives
   B. Improve county-hospital-interagency dynamics and collaborations
   C. Increase inpatient psychiatric bed capacity and access to other community psych services

3. **Addressing Emergency Department Crowding – TOP CONCERNS**
   A. Address high frequency emergency department utilizers (homeless, mentally ill, pain management)
   B. Need for alternate sites of services (primary care, urgent care, social services, sobering centers)

   Addressing Emergency Department Issues – SUGGESTIONS
   A. Address Local Emergency Services Authority's (LEMSA) aggressive behavior such as fees and fines
   B. Address high frequency emergency department utilizers (homeless, mentally ill, pain management)
   C. Provide alternate sites of services in the community and allow paramedics to direct patients according to need (e.g. sobering center)

4. **Addressing Local Emergency Medical Services Agency Transport Policies – TOP CONCERNS**
   A. Poor Emergency Medical Services (EMS) policies/dynamics/control of quality/fees
   B. Lack of alternate sites of services in the community

Addressing Emergency Department Fees and Fines – TOP CONCERNS

A. EMS/County shifting (clogging) the burden of care from the County to the Hospital (e.g.: homelessness) which in turn clogs the emergency department, and then imposing fines on the hospital for missed metrics (e.g.: off load, patient throughput)
B. No value "add" to increased fines ("add to the bureaucracy")
C. Not an issue

5. **Enhancing Quality and Patient Safety – TOP CONCERNS**
   A. Rules/Regulations/Unfunded Mandates
   B. Too many metrics and required reporting from too many outside organizations that have conflicting, overlapping, unreliable metrics and standards

Enhancing Quality and Patient Safety – SUGGESTIONS

A. Develop a common platform, streamlining for quality reporting
B. Improve intra-agency collaborations and efficiencies in reporting, metrics determination and standards

6. **Tackling Workforce Shortages – TOP CONCERNS**
   A. Nursing shortage – need for increased quality nursing with improved training and compensation
   B. Salary competition for nurses (by the deep-pockets of the larger urban centers)
   C. Insufficient training programs and insufficient affordable housing

7. **Supporting Labor Relationship & Negotiations – TOP CONCERNS**
   A. Aggressive union tactics
   B. Unions influence/power with legislators
   C. Union activity adds no real value but drives up costs to the hospital
   D. Union fines and fees

Tackling Workforce Shortage and Supporting Labor Relationship & Negotiation – SUGGESTIONS

A. Educate legislators on the aggressive union lobby activities
B. Highly focused advocacy that takes on big labor unions on union-led initiatives/legislation that would hurt the hospitals
C. Regional collaborations and hospital planning to address nursing costs and affordability

8. **Supporting Population and Community Health Improvement – TOP CONCERNS**
   A. Adequate resources that support expanded access to services – behavioral health, services for homeless, primary care, substance abuse
   B. Need for improved funding for social services and collaborations with local government and other community agencies that address social determinants of health

9. **Addressing Health Outcome Disparity – TOP CONCERNS**
   A. Adequate resources that support expanded access to services – behavioral health, services for homeless, primary care, substance abuse disorder
   B. Need for improved funding for social services and collaborations with local government and other community agencies that address social determinants of health (e.g. housing, food security)

Supporting Population and Community Health and Health Outcomes Disparity – SUGGESTIONS

A. Align community collaboration strategies, share models and best practices, focus all hospitals on the same efforts for real leveraged impact
B. Strengthen public social services availability in the community; improve collaborations with the County and community agencies

10. Improving Health Information Exchange Across All Entities – TOP CONCERNS

A. Lack of standard platform (and too many disparate platforms)
B. Inability for portability/interoperability and meaningful data sharing
C. Costs

Improving Health Information Exchange Across All Entities – SUGGESTIONS

A. Support Emergency Department Information Exchange (EDIE) and CareLink
B. Support standardized platforms (if not just one platform used by all)

11. Improving Cybersecurity – TOP CONCERNS

A. Cyberattack; data breach

Improving Cybersecurity - SUGGESTIONS

A. Improve communications across hospitals regarding threats and best-practice solutions
B. Improve staff training/education

12. Increased Emphasis on Disaster Preparedness – TOP CONCERNS

A. Inadequate funding/unfunded mandate
B. Intra-agency collaboration, communication, education and training e.g.: incident command
C. Ability to respond as a provider community to major disaster like earthquake, fire, active shooter or health/disease outbreak (e.g.: due to the homeless populations in Los Angeles and San Francisco)

Increased Emphasis on Disaster Preparedness – SUGGESTIONS

A. Provide increased funding (through EMS) and support for intra-agency collaborations, training and education opportunities.

13. Addressing Medicare Reimbursement Issues – TOP CONCERNS

A. Reimbursement rate cuts (and rates not keeping pace with cost inflations)
B. Cost shifting
C. Changes to wage index
D. Volume increases and population growth

14. Addressing Medi-Cal Reimbursement Issues – TOP CONCERNS

A. Reimbursement rate cuts and denials
B. Cost shifting
C. Underfunding of care in non-inpatient settings such as outpatient, emergency department, mental health, skilled nursing facilities, population health initiatives

15. **Addressing Commercial Reimbursement Issues – TOP CONCERNS**
    A. Commercial Insurance "gaming" including cuts, denials, delays/stalled payments
    B. Inadequate reimbursement overall
    C. Surprise billing/rate setting
    D. Legislation/legislators that favor insurance companies over hospitals

16. **Addressing Other Reimbursement Issues – TOP CONCERNS**
    A. Insurance "gaming" including cuts, denials, delays/stalled payments
    B. Inadequate reimbursement overall

All Reimbursement Issues – SUGGESTIONS
    A. Build consensus and action around healthcare financing reform
    B. Payer transparency in negotiations
    C. Simplify, standardize the processes across all payers

17. **Local Government Regulations – TOP CONCERNS**
    A. CDPH and OSHPD
    B. County/State EMSA dynamics (lack of real value, collaboration)
    C. Lack of social services availability and funding, particularly mental health services and services for homeless like adequate housing and food security

18. **State Government Regulations – TOP CONCERNS**
    A. CDPH and OSHPD
    B. Nurse staffing ratios
    C. Inadequacy and deterioration of Medi-Cal and Medicare reimbursement and funding
    D. Unfunded mandates like seismic upgrades requirements

19. **Federal Government Regulations – TOP CONCERNS**
    A. Inadequacy and deterioration of Centers for Medicare and Medicaid Services reimbursement and funding
    B. Out-dated rules and regulations
    C. Outdated Stark Law

All Government Regulations - SUGGESTIONS
    A. Fight to lessen unfair and burdensome government regulations and constraints
    B. Improve government relations and collaborations, and increase education to legislators on issues faced by hospitals
    C. Develop aligned vision and incentives

American Hospital Association™

Advancing Health in America

2020 Environmental SCAN

The AHA's 2020 Environmental Scan is sponsored by:

B.E. SMITH®
an AMN Healthcare company

Welcome to the 2020 Environmental Scan

They say that change is the only constant in life. That certainly holds true today. Fresh technologies, new players in the market, increased emphasis on population health and social determinants of health, the advance of consumer-friendly care delivery models … all of these factors and more promise a significant and lasting transformation of health care.

For those in health care, we *welcome* this change. Because as we have always done, hospitals and health systems are leading this transformation, helping to shape and direct the future.

As a field, we have a remarkable track record for adaptability, seamlessly integrating decades of major breakthroughs in technology, biology and science — evolving treatments for cancer come to mind — into improved patient care.

In health care, change brings with it the opportunity to continue improving. It means better care for our patients. Change is what hospitals have been doing for far longer than any of us have been around. We know that there will always be changes we need to make to prepare for the future. That's what we're doing today.

RICK POLLACK

President and CEO
American Hospital Association

To help you, each year, we publish the AHA Environmental Scan. This year's scan offers an overview of the trends, statistics and economic forecasts likely to affect patients and providers at every level of care.

We track, interpret and share developments to make your job easier. With that in mind, we have identified several key topic areas that will likely impact health care in 2020 and beyond.

• **Access.** The cornerstone of healthy communities is having access to the right care at the right time in the right setting. Many factors affect this: availability of government programs such as Medicare, Medicaid and the Children's Health Insurance Program, private insurance coverage and a strong and resilient workforce.

• **Health.** The health care system continues to evolve beyond the walls of the hospital as hospitals and health systems seek to manage and prevent chronic disease and improve the well-being of patients. This includes addressing the social determinants of health such as housing, food insecurity and violence in partnership with community organizations, providing access to behavioral health resources and working to stem the tide of tragic drug overdose.

• **Innovation.** Innovative strategies are becoming the norm. Eighty-six percent of health systems have at least one executive dedicated to exploring partnerships, investments and other tactics to position for the future. Top priorities for innovation initiatives and investments will include IT/data analytics, patient/consumer engagement and use of artificial intelligence to improve care delivery.

• **Affordability and value.** Affordable health care is one of the biggest concerns facing families, employers and government. Hospitals and health systems are doing their part to make care more affordable. They are leading the charge toward value-based care with new models that provide better coordinated care at a lower cost. They are using the best technology and data to improve patient outcomes.

• **Individual as partner.** Today's consumers want health care when and where they want it. The availability of virtual care, patient-friendly online portals and alternative places of care such as retail clinics will be more important than ever.

This scan offers facts, predictions and statistics to think about and plan for, but nothing to fear. We've embraced change in the past and grown from it, and we will again.

As always, the AHA will stay on top of it as part of our commitment to helping America's hospitals and health systems as they care for their communities … saving lives, performing miracles and keeping people healthy.

ACCESS

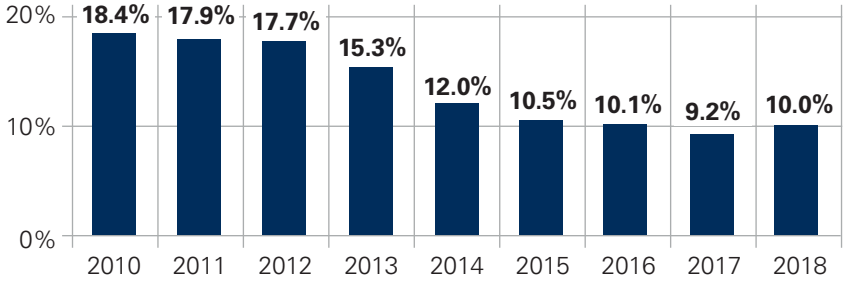
Access to affordable, equitable health, behavioral and social services

Hospitals, health systems and health care organizations recognize that access to care for individuals is the cornerstone for developing healthy communities across the nation. Insurance coverage and a strong workforce are key elements that influence access to health care.

COVERAGE

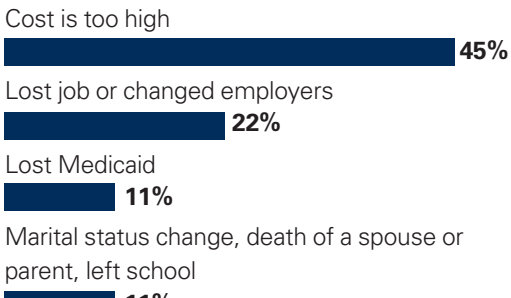
The Uninsured

UNINSURED RATE: YOUNGER THAN 65



"Health Insurance Coverage in the United States, 2013-2018" and "Income, Poverty, and Health Insurance Coverage in the United States: 2010-2012," www.census.gov/topics/health/health-insurance/library.html, U.S Census Bureau.

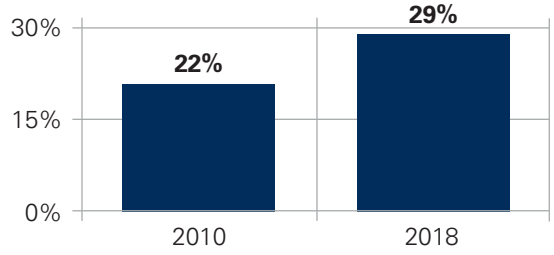
TOP REASONS FOR BEING UNINSURED AMONG NONELDERLY ADULTS



Source: "Key Facts about the Uninsured Population," Kaiser Family Foundation, kkf.org, Dec. 7, 2018.

The Underinsured

UNDERINSURED RATE: ADULTS AGES 19-64



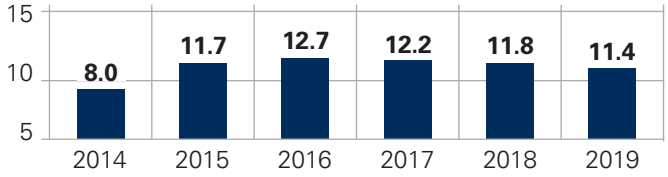
- In 2018, high out-of-pocket costs and deductibles contributed to underinsurance.
- The greatest growth in the number of underinsured adults occurred among those with employer plans.
- Continuously insured adults, including the underinsured, are more likely to get preventive care and cancer screenings.

Collins, Sara R. et al. "Health Insurance Coverage Eight Years After the ACA: Fewer Uninsured Americans and Shorter Coverage Gaps, But More Underinsured," The Commonwealth Fund, Feb. 7, 2019.

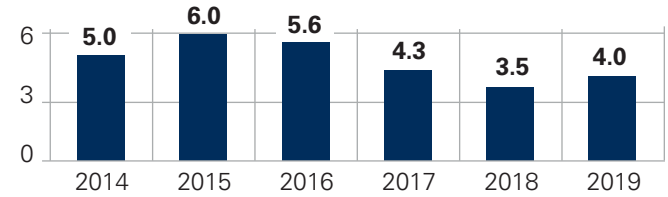
The Affordable Care Act (ACA)

The ACA individual marketplace

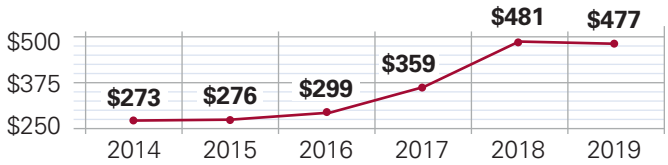
MARKETPLACE ENROLLMENT (in millions)



AVERAGE NUMBER OF PARTICIPATING INSURERS PER STATE

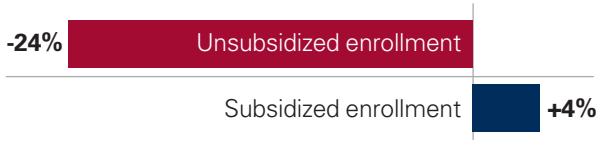


MARKETPLACE AVERAGE BENCHMARK PREMIUM



Note: Average calculated using second -lowest cost silver plans per market.
"Marketplace Enrollment, 2014-2019, Marketplace Average benchmark premiums, Number of Issuers Participating in the Individual Health Insurance Marketplaces" Kaiser Family Foundation, kkf.org. Accessed July 29, 2019.

IMPACT OF SUBSIDIES ON ENROLLMENT (between 2017 and 2018)



"Trends in Subsidized and Unsubsidized Enrollment," Centers for Medicare & Medicaid Services, Aug. 12, 2019.

The ACA linked to reduced disparities

- Gaps in insurance coverage among racial and ethnic groups decreased after implementation of the ACA coverage expansions. These effects were greatest in states that expanded Medicaid.*
- Under the ACA, women with ovarian cancer were more likely to be diagnosed at an early stage and receive treatment within 30 days of diagnosis.†

* Chaudry, Ajay et al. "Issue Brief: Did the Affordable Care Act Reduce Racial and Ethnic Disparities in Health Insurance Coverage?" The Commonwealth Fund, August 2019.
† Smith, Anna Jo and Nickels, Amanda. "Impact of the Affordable Care Act on early-stage diagnosis and treatment for women with ovarian cancer," *Journal of Clinical Oncology*, vol. 37, no. 18, June 5, 2019. Reprinted with permission. © 2019 American Society of Clinical Oncology. All rights reserved.

AFRICAN AMERICAN CANCER PATIENTS

+6% Increase in African American patients beginning treatment within a month of receiving diagnoses of advanced cancers in Medicaid expansion states post-expansion.

Doerr, Anne. "Yale study finds link between Medicaid expansion and equity in cancer care," *YaleNews*, June 2, 2019.

Medicare

As measured by expenditures, Medicare is the largest health care insurance program in the U.S.

2017 ENROLLMENT

	No. of people	% of U.S. population
Medicare Part A	**58 million**	**18.0%**
Medicare Part B	**53 million**	**16.0%**
Medicare Part D	**44 million**	**13.5%**

Klees, Barbara S. and Wolfe, Christian J. "Brief Summaries of Medicare & Medicaid," Office of the Actuary, CMS, Department of Health & Human Services, Oct. 15, 2018.

Impact of a potential Medicare public option

- By 2025, 6.3 million people would gain coverage, as opposed to 9.1 million people gaining coverage through additional support of the ACA.
- A reduction of $836 billion to hospitals over a 10-year period.
- A significant disruption to the employer-sponsored insurance market, which provides coverage to more than 150 million Americans.

Koenig, Lane et al. "The Impact of Medicare-X Choice on Coverage, Healthcare Use, and Hospitals," KNG Health Consulting, LLC, March 12, 2019, and supplemental report August 6, 2019.

Medicaid and the Children's Health Insurance Program (CHIP)

ENROLLMENT

- More than 72 million people, or 22% of the U.S. population.
- Medicaid expansion adult enrollment: nearly 17 million people.
- 47% of Medicaid and CHIP recipients are younger than 21.
- 11% of Medicaid recipients are 65 years or older.

"Who enrolls in Medicaid and CHIP," Medicaid.gov, July 28, 2019.

MEDICAID PAYS:

- $1 in $6 in the health care system.
- $1 in $3 to safety net hospitals and health centers.
- $1 in $2 for long-term care.
- For nearly half of all births in a typical state.

"Medicaid in the United States," fact sheet, Kaiser Family Foundation, November 2018.
Rudowitz, Robin, et al. "10 things to Know about Medicaid: Setting the Facts Straight," Kaiser Family Foundation, March 6, 2019.

WORKFORCE

Workforce shortages

PHYSICIAN SHORTAGE PROJECTIONS BY 2032

Primary care physicians	**21,100-55,200**
Non-primary care specialties	**24,800-65,800**
Surgical specialties	**14,300-23,400**

"2019 Update: The Complexities of Physician Supply and Demand: Projections from 2017 to 2032," prepared for the Association of American Medical Colleges; submitted by IHS Markit Ltd., April 2019.

HEALTH CARE WORKFORCE SHORTAGE PROJECTIONS BY 2025

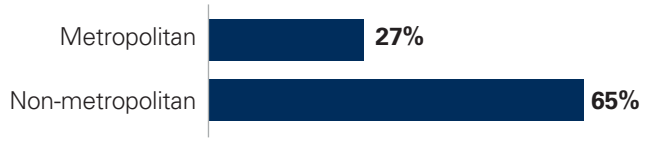
Home health aides	**446,300**
Nursing assistants	**95,000**
Medical and lab technologists/technicians	**98,700**
Nurse practitioners	**29,400**

Stevenson, Matthew. "Demand for Healthcare Workers Will Outpace Supply by 2025: An Analysis of the US Healthcare Labor Market," Mercer HPA, May 2018.

PSYCHIATRIST SHORTAGES BY 2030

Behavioral Health Workforce Projections, 2016-2030," HRSA National Center for Health Workforce Analysis, 2018.

PERCENTAGE OF COUNTIES WITHOUT A PSYCHIATRIST



Andrilla, C. Holly A. et al. "Geographic Variation in the Supply of Selected Behavioral Health Providers," *American Journal of Preventive Medicine*, vol. 54, no. 6, supplement 3 (June 2018): S199-S207.

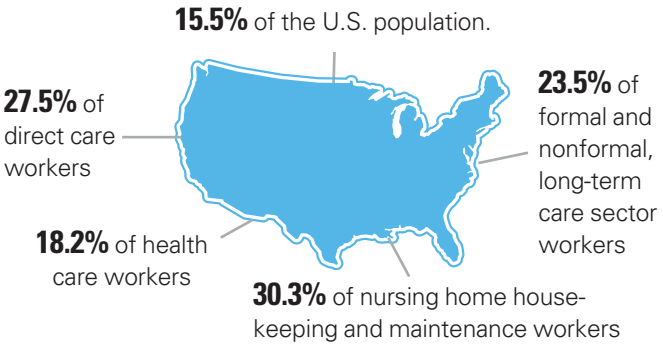
NURSING EDUCATION CAPACITY

75K Number of qualified applicants turned away from baccalaureate and graduate nursing programs by U.S. nursing schools in 2018 due to an insufficient number of faculty, clinical sites, classroom space, clinical preceptors and budget constraints.

"Fact Sheet: Nursing Faculty Shortage," American Association of Colleges of Nursing, aacnnursing.org, April 2019.

Workforce and immigration

IN 2017, IMMIGRANTS* ACCOUNTED FOR:



*Immigrants are defined as those born outside the U.S. and are naturalized citizens, legal noncitizens and unauthorized immigrants.
Zallman, Leah et al. "Care For America's Elderly And Disabled People Relies On Immigrant Labor," *Health Affairs*, vol. 38, no. 6 (June 2019).

Drivers of workforce changes

- Generational shifts
- Technology
- Consumerism
- Open talent models (e.g. gig, virtual and contract)
- Diversity*

Radin, Jennifer et al. "The future of work: How can health systems and health plans prepare and transform their workforce?" *Deloitte Insights*, Deloitte Center for Health Solutions, March 7, 2019. © 2019 Deloitte Development LLC.

*"The Imperative for Strategic Workforce Planning and Development: Challenges and Opportunities," American Hospital Association, 2017.

Artificial intelligence (AI) and the workforce

PERCENTAGE OF TASKS THAT COULD BE AUTOMATED IN HEALTH CARE

Implications:

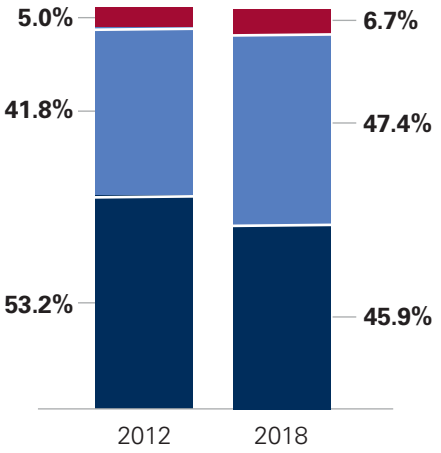
- Improved efficiency, productivity and performance.
- Expanded job responsibilities.
- Practicing at the top of license.
- "Soft" skills will matter more.
- Workforce will acquire new digital skills to be able to collaborate with AI teams.

"AI and the Health Care Workforce," Market Insights, AHA Center for Health Innovation, Sept. 23, 2019.

Learn More at AHA.ORG

Learn more about the AHA's workforce agenda: **aha.org/workforce**

Distribution of physicians by employment status

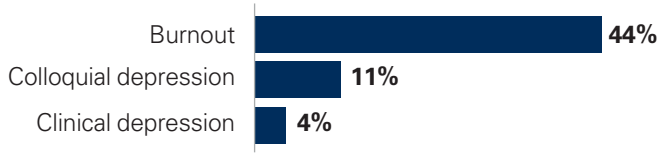


- 2018 marked the first year in which there were fewer physician owners than employees.

Kane, Carol. Policy Research Perspectives — "Updated Data on Physician Practice Arrangements: For the First Time, Fewer Physicians are Owners Than Employees," AMA Economic and Health Policy Research, American Medical Association, May 2019.

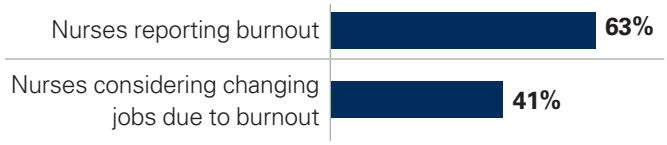
Clinician burnout

PHYSICIAN BURNOUT AND DEPRESSION



Kane, Leslie. "Medscape National Physician Burnout, Depression & Suicide Report 2019," Medscape, Jan. 16, 2019.

NURSE BURNOUT



"Wake Up to the Facts About Fatigue eBook," Kronos, 2018.

PHYSICIAN BURNOUT COST*

Focusing on physician turnover and reduced clinical hours, the annual cost of burnout on a national scale:

$4.6 billion, or $7,600 per employed physician

NURSE BURNOUT COST†

Annual cost of nurse burnout to the average hospital:

$5.2 – $8.1 million

* Han, Shasha et al. "Estimating the Attributable Cost of Physician Burnout in the United States," *Annals of Internal Medicine*, vol. 170, no. 11 (2019): 784-790.
† "2016 National Healthcare Retention & RN Staffing Report," NSI Nursing Solutions Inc., March 2016.

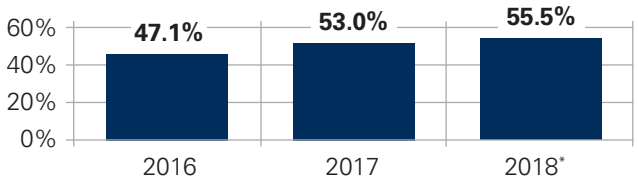
Nonmedical tasks take time

- Primary care physicians spend more than one-half of their workday, nearly 6 hours, interacting with the EHR during and after clinic hours.*
- During the time spent interacting with the EHR, 44% is focused on administrative tasks like order entry and billing and coding, and 24% is focused on inbox management.*
- An ED physician makes 4,000 mouse clicks over the course of a shift.†

* Arndt, Brian G. et al. "Tethered to the EHR: Primary Care Physician Workload Assessment Using EHR Event Log Data and Time-Motion Observations," *Annals of Family Medicine*, vol. 15 no. 5 (Sept./Oct. 2017): 419-426.
† Fry, Erika and Schulte, Fred. "Death by a Thousand Clicks: Where Electronic Health Records Went Wrong," *Fortune*, March 18, 2019.

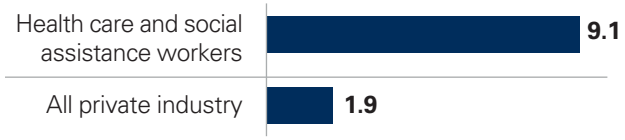
Workplace violence

HOSPITALS THAT HAVE FORMAL WORKPLACE VIOLENCE PREVENTION PROGRAMS



AHA Annual Survey of Hospitals data, American Hospital Association, 2017 - 2019
* 2018 data is preliminary.

RATE OF INTENTIONAL INJURIES BY OTHERS, PER 10,000 WORKERS IN 2017



"Injuries, Illnesses, and Fatalities," Department of Labor, Bureau of Labor Statistics, www.bls.gov/web/osh/cd_r8.htm. Accessed Aug. 7, 2019.

VIOLENCE IN THE EMERGENCY DEPARTMENT (ED)

- Nearly half of emergency physicians stated they have been physically assaulted at work.
- 71% personally witnessed others being assaulted during their shifts.
- 96% of female emergency physicians and 80% of male emergency physicians reported that a patient or visitor made inappropriate or unwanted advances toward them.

"ACEP Emergency Department Violence Poll Research Results," Marketing General Inc. and the American College of Emergency Physicians, September 2018.

Learn More at AHA.ORG

Learn more about the AHA's Hospitals Against Violence initiative: **aha.org/workplace-violence**

American Hospital Association™
Advancing Health in America

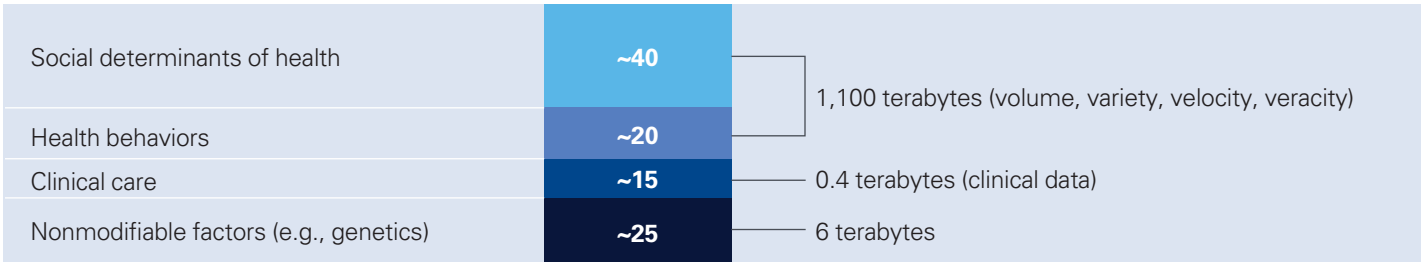
HEALTH

Focus on holistic well-being in partnership with community resources

The health care system is evolving outside the walls of the hospital and into the community in an effort to manage and prevent chronic disease and improve the well-being of patients.

Social determinants of health

SOCIETAL ISSUES HAVE A MAJOR IMPACT ON CONSUMER HEALTH



Note: This graphic has been adjusted from the original version.
Singhal, Shubham and Carlton, Stephanie. "The era of exponential improvement in healthcare?" McKinsey & Company, May 2019.

HOUSING*

- 11% of households spend more than half their income on housing costs.
- Severe housing-cost burden is associated with an increase in food insecurity, child poverty and people in fair or poor health.

FOOD INSECURITY†

- 11.8% of households were food insecure in 2017.
- 40 million people lived in food-insecure households.

* Givens, Marjory et al. "2019 County Health Rankings Key Findings Report," Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, March 2019.
† "Food Security Status of U.S. Households in 2017," Department of Agriculture, Economic Research Service, www.ers.usda.gov, Sept. 5, 2018.

SOCIAL DETERMINANTS AND YOUTH VIOLENCE

Many risk factors of youth violence are the result of chronic stress from living in impoverished neighborhoods or poor housing, food insecurity, racism and other instability.

- Each day, 14 young people become victims of homicide and 1,300 are treated in EDs for nonfatal, assault-related injuries.

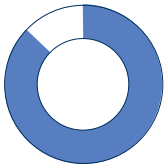
$21 BILLION Estimated cost of youth violence annually

1 in 5 high school students reported being bullied at school

"Preventing Youth Violence — Fast Facts," Centers for Disease Control and Prevention, cdc.gov, Feb. 26, 2019.

Hospitals and social determinants

SCREENING FOR SOCIAL DETERMINANTS



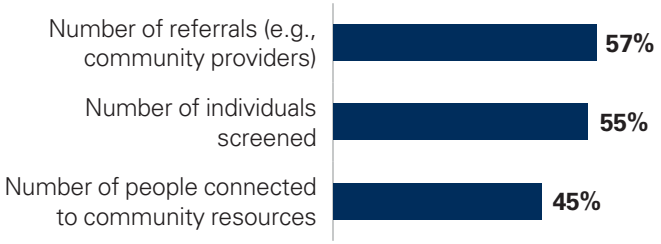
88% of hospitals screen for social needs.

UNMET SOCIAL NEEDS ARE ASSOCIATED WITH:

- Nearly twice the rate of depression.
- 60% higher prevalence of diabetes.
- More than double the rate of ED visits.
- More than double the rate of missed medical appointments.

TOP 3 GOALS UNDERLYING HOSPITALS' STRATEGY ON HEALTH-RELATED SOCIAL NEEDS

TOP 3 TYPES OF SOCIAL NEEDS METRICS TRACKED BY HOSPITALS



Lee, Josh and Korba, Casey. "Social determinants of health: How are hospitals and health systems investing in and addressing social needs?" Deloitte Center for Health Solutions, 2017. © 2017 Deloitte Development LLC.

Behavioral health

NATIONAL LANDSCAPE

1 in 5 Americans affected by behavioral health disorders

- 70% of adults with behavioral health disorders also have physical health conditions.
- Costs are 75% higher for people with both behavioral and physical conditions.
- Fewer than half of adults with any mental health disorder receive treatment.

"Behavioral Health Care is High-Value Care," American Hospital Association, May 2019.

HOSPITALS, HEALTH ORGANIZATIONS AND BEHAVIORAL HEALTH

- Nearly 30% of patients who visited a hospital ED had at least one behavioral health diagnosis.

2,538 Number of community mental health centers in operation across the country in 2017

"Behavioral Health Integration: Treating the Whole Person," American Hospital Association Center for Health Innovation, 2019.

PERCENTAGE OF HOSPITALS REPORTING INTEGRATION OF ROUTINE BEHAVIORAL HEALTH SERVICES INTO THE FOLLOWING AREAS:

AHA Annual Survey of Hospitals data, American Hospital Association, 2019. Data is preliminary.

Major depression

DEPRESSION AND TREATMENT IN THE U.S.

People in the U.S. reporting at least one major depressive episode in 2017:

	No. of people	% of the respective population	% not receiving treatment
Adults	**17.3 million**	**7.1%**	**35.0%**
Adolescents (ages 12 to 17)	**3.2 million**	**13.3%**	**60.1%**

- The prevalence of adults with a major depressive episode was highest among individuals ages 18 to 25.
- The prevalence of a major depressive episode was 13.2% higher among adolescent females compared with males.

"Major Depression," National Institute of Mental Health, www.nimh.nih.gov, February 2019.

Suicide

IN 2017:

- More than 47,000 Americans died by suicide.
- The most common method of suicide — firearm (51%).
- Tenth-leading cause of death in the U.S.
- Second-leading cause of death among individuals ages 10-34.
- There were twice as many suicides as there were homicides.
- 4.3% of adults 18 and older had thoughts about suicide.

Suicide Statistics, National Institute of Mental Health, www.nimh.nih.gov, April 2019.

Veterans' behavioral health

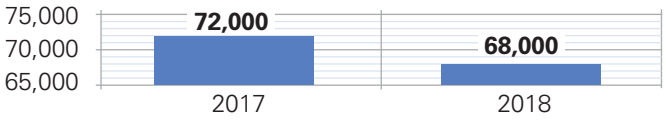
- About 20 former and current veterans die by suicide each day.
- The suicide rate is 22% higher than the general population.
- The Department of Veterans Affairs (VA) is using algorithms to identify potential veterans at risk.
- Since the VA adopted this technology in 2017, 250 fewer veterans have died by suicide than would have been expected based on the previous rate.

Ravindranath, Mohana. "How the VA uses algorithms to predict suicide," *Politico*, June 25, 2019.

Reversing the tide of drug misuse

DRUG OVERDOSES

Preliminary data from the CDC indicates that overdose deaths declined 5.1% in 2018, the first drop in the U.S. since 1990.

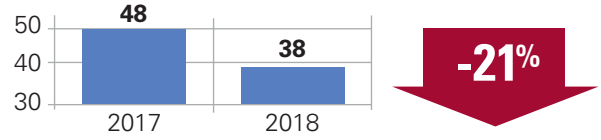


- Deaths from heroin and prescription painkillers are decreasing.

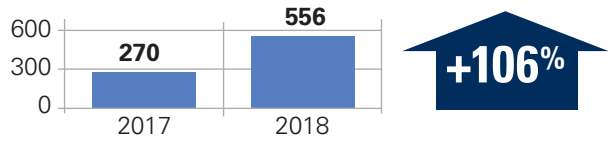
Finnegan, Joanne. "Decline in opioid prescriptions translates to drop in drug overdose deaths for the first time in decades," FierceHealthcare.com, July 18, 2019.

Opioids and naloxone

HIGH-DOSE OPIOID PRESCRIPTIONS (in millions)

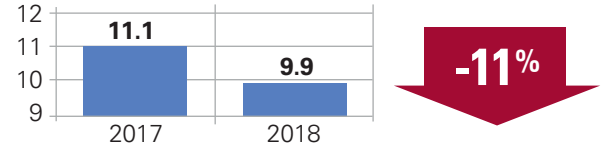


NALOXONE PRESCRIPTIONS INCREASE (in thousands)



Guy, Gery Jr. et al. "Vital Signs: Pharmacy-Based Naloxone Dispensing — United States, 2012–2018," Morbidity and Mortality Weekly Report, (2019) 68:679–686.

MISUSE OF PRESCRIPTION PAIN RELIEVERS BY U.S. RESIDENTS 12 OR OLDER (in millions)



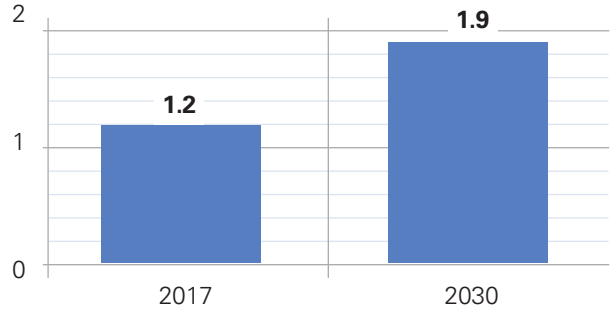
"Key Substance Use and Mental Health Indicators in the United States: Results from the 2018 National Survey on Drug Use and Health," Department of Health & Human Services, Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality, HHS Publication No. PEP19-5068, 2019.

Aging population

AMERICANS 65 AND OLDER

	No. of people	% of population
2018	**52 million**	**16%**
2060	**95 million**	**23%**

AMERICANS 65 AND OLDER REQUIRING NURSING HOME CARE (in millions)



Mather, Mark. et al. "Fact Sheet: Aging in the United States," Population Reference Bureau, July 15, 2019.

LONELINESS

Older adults ages 50 to 80:

- Chronic loneliness can impact memory, physical well-being, mental health and life expectancy.

Solway, Erica et al. "Loneliness and health," University of Michigan Institute for Healthcare Policy and Innovation's National Poll on Healthy Aging, March 2019.

ALZHEIMER'S DISEASE

- The sixth-leading cause of death in the U.S.
- 5.8 million Americans are living with the disease.
- By 2050, it is projected that 14 million Americans will have the disease.
- Every 65 seconds someone in the U.S. develops the disease.

$290 BILLION In 2019, Alzheimer's and other dementia will cost the nation $290 billion. By 2050, these costs could rise to **$1.1 trillion**.

"2019 Alzheimer's Disease Facts and Figures Infographic" Alzheimer's Association, alz.org, 2019.

Learn More at **AHA.ORG**

Learn more about the AHA's efforts to create age-friendly health systems: **aha.org/agefriendly**

INNOVATION

Seamless care propelled by teams, technology, innovation and data

The health care field is transforming. The digital health evolution, consumerism, clinical advancements, new entrants and unique partnerships are accelerating this transformation. Hospitals and health systems are taking a leadership role in preparing for the future by investing in innovative technologies, practices and cultures with the goals of improving outcomes, addressing affordability and reducing friction for individuals.

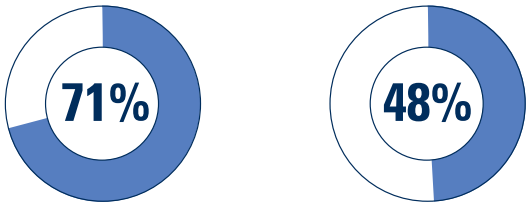
Health system innovation

TOP PRIORITIES FOR INNOVATION INITIATIVES AND INVESTMENTS

Innovation infrastructure

86% of health systems have one or more executives responsible for innovation strategy and oversight.

HEALTH SYSTEMS THAT HAVE A DEFINED DEPARTMENT DEDICATED TO INNOVATION



Forces driving health system innovation

- Prioritizing consumerism.
- Disruption from new entrants.
- Improving quality of care.
- Increasing value-based contracting.
- Decreasing operating margins.

INNOVATION INVESTMENT

14% of health systems have a formal investment or ventures arm.

MOST COMMON HEALTH SYSTEM INNOVATION PARTNERSHIPS

SPEED OF IMPLEMENTING AND SCALING INNOVATION

- 38% of health systems report the ability to scale quickly.
- 88% of health systems with a formal process for scaling innovation report the ability to scale quickly.

"Trends for Scaling Innovation in Health Care," Center for Connected Medicine and the Health Management Academy, June 2019.

Health IT

Based on a survey of health care IT leaders

TOP HEALTH CARE IT SECTORS TO EXPERIENCE GROWTH IN THE NEXT YEAR

TOP CHALLENGES TO HEALTH CARE IT INNOVATION IN THE NEXT YEAR

Roberts, Bryan. "2019 Healthcare Prognosis," Venrock, April 12, 2019.

Digital Health Forecast

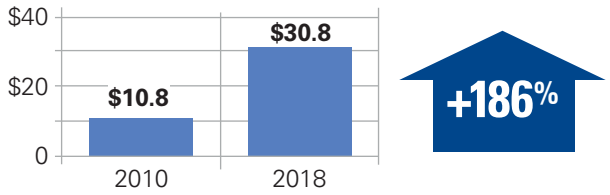
Health care IT leaders predict that digital health innovators will work to demonstrate real-world applications.

Examples:

- Broader adoption of AI and machine learning in population health to improve identification of those at risk and delivery of personalized services.
- Virtual reality/augmented reality as a routine treatment for pain control.
- Wearables and implantable health devices to enable detection of chronic conditions and monitor treatments.
- Broader use of voice recognition and intelligent assistants to reduce clinician burden.
- Increased use and impact of digital therapeutics.

"2019 Healthcare Trends Forecast: The Beginning of a Consumer-Driven Reformation," Healthcare Information and Management Systems Society (HIMSS), 2019.

HEALTH TECH AND DIGITAL HEALTH INVESTMENTS (in billions)

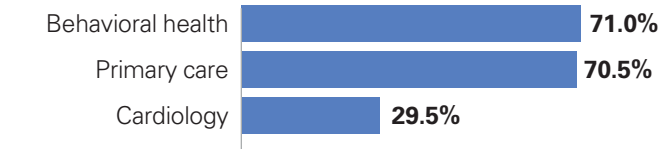


Singhal, Shubham and Carlton, Stephanie. "The era of exponential improvement in healthcare?" McKinsey & Company, May 2019.

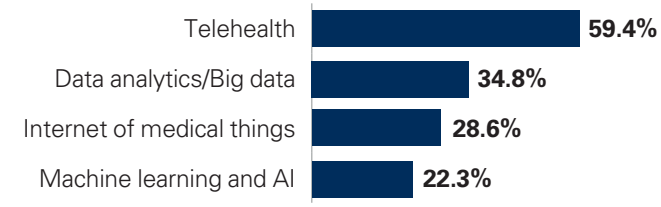
Disruptive innovation

Based on a survey of health care leaders

SERVICE LINES MOST RIPE FOR DISRUPTION FROM TECHNOLOGY

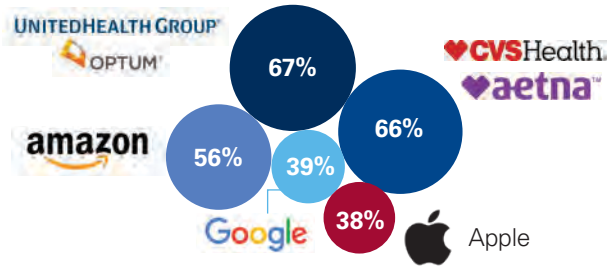


TECHNOLOGY THAT WILL HAVE THE BIGGEST IMPACT ON HEALTH CARE IN 2020



Survey to Health Care Leaders and Strategists, AHA Society for Health Care Strategy & Market Development, June 2019.

ORGANIZATIONS POSING STRONG COMPETITION TO HOSPITALS AND HEALTH SYSTEMS

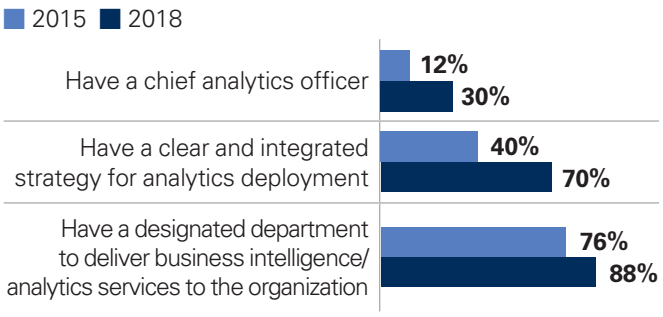


Crnkovich, Paul et al. "2019 State of Consumerism in Healthcare: The Bar is Rising," Kaufman Hall, 2019.

Health analytics

- Health systems with a higher number of value-based care arrangements are more likely to have a mature approach to analytics.

HEALTH SYSTEMS' INVESTMENT IN ANALYTICS



Hagan, Alison et al. "Shifting into high gear: Health systems have a growing strategic focus on analytics today for the future," *Deloitte Insights*, Deloitte Center for Health Solutions, 2019. © 2019 Deloitte Development LLC.

BESmith.com
855.296.6318

THE DYNAMICS OF HEALTHCARE ARE SHIFTING

OUR LEADERS KEEP HOSPITALS HEALTHY.

A leadership opening can be an opportunity to re-engineer processes and re-energize your team. B.E. Smith is a strategic partner uniquely equipped to engage and secure the right talent across the continuum from managers to executives.

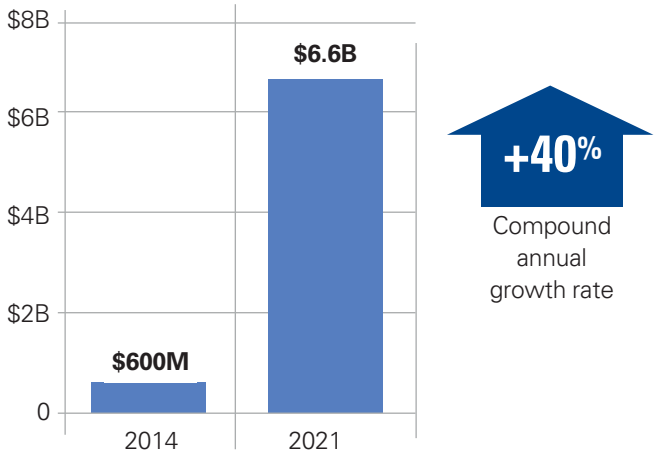
We work in collaboration with our clients and our candidates to ensure we are placing and supporting the right people, in the right place, at the right time. They consistently improve clinical, financial, and operational performance; reduce disruption; and enhance the patient experience.

GET TO KNOW

B.E. SMITH®
an AMN Healthcare company

Artificial Intelligence (AI)

HEALTH AI MARKET SIZE



Collier, Matt, Fu, Richard and Yin, Lucy. "Artificial Intelligence: Healthcare's New Nervous System," Accenture, June 2017.

10 AI applications with the greatest near-term impact in health care

- Robot-assisted surgery
- Virtual nursing assistants
- Administrative workflow assistance
- Fraud detection
- Dosage error reduction
- Connected machines
- Clinical trial participant identifier
- Preliminary diagnosis
- Automated image diagnosis
- Cybersecurity

$150 BILLION possible resulting savings by 2026

Collier, Matt, Fu, Richard and Yin, Lucy. "Artificial Intelligence: Healthcare's New Nervous System," Accenture, June 2017.

Personal genetic data

- By the start of 2019, more than 26 million consumers added their DNA to four leading commercial ancestry and health databases.
- As many people purchased consumer DNA tests in 2018 as in all previous years combined.
- If the pace continues, these companies could have the genetic makeup of more than 100 million people by the start of 2021.

Regalado, Antonio. "More than 26 million people have taken an at-home ancestry test," MIT Technology Review, Feb. 11, 2019.

Internet of Things (IoT)

AVERAGE NUMBER OF INTERNET-CONNECTED DEVICES PER PERSON IN THE U.S.

Cisco "Complete Visual Networking Index (VNI) Forecast, 2017-2022."

Opportunities and challenges of IoT

Opportunities:

Telehealth and remote monitoring, smart sensors, medical device integration, health care building facilities that optimize clinical processes and operational systems, voice assistants, robotics, smart pills and treatments of diseases.†

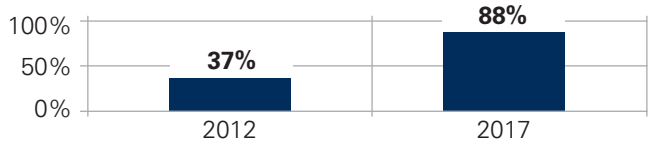
Challenges:

Data storage capability, cyberrisk, the need to update hospital infrastructure and human error.‡

† "IoT in Healthcare: Are We Witnessing a New Revolution?" Sciforce, Medium.com, Mar. 7, 2019.
‡ Matthews, Kayla. "5 Challenges Facing Health Care IoT in 2019," iotforall.com, Dec. 27, 2018.

Interoperability

PERCENTAGE OF HOSPITALS THAT SEND RECORDS TO AMBULATORY CARE PROVIDERS OUTSIDE THEIR SYSTEMS



BARRIERS TO INTEROPERABILITY

Other providers do not have an EHR or lack capability to receive information	63%
Experience challenges sending/receiving data across different vendor platforms	57%
Difficult to match or identify the correct patient between systems	37%
Additional costs to send/receive data with organizations outside system	35%
Had to develop customized interfaces to exchange information electronically	28%

"Sharing Data, Saving Lives: The Hospital Agenda for Interoperability," American Hospital Association, January 2019.

Learn More at AHA.ORG

Learn more about the AHA Center for Health Innovation: **aha.org/center**

American Hospital Association™
Advancing Health in America

AFFORDABILITY AND VALUE

The best care that adds value to lives

Affordable health care is one of the biggest concerns facing families, employers and government. Health care transformation and value-based care models focusing on populations can improve the quality of care at a lower cost.

COST TO STAKEHOLDERS

U.S. national health expenditures

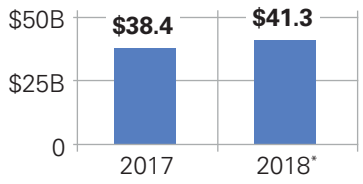
Year	% growth	Amount	% of GDP
2017	**3.9%**	**$3.5 trillion**	**17.9%**
2018*	**4.4%**	**$3.6 trillion**	**17.8%**
2019*	**4.8%**	**$3.8 trillion**	**17.8%**
2020-2027*	**5.7% average**	**$6.0 trillion by 2027**	**19.4% by 2027**

*Projection

National Health Expenditures Projections 2018-2027 — Tables, Office of the Actuaries Actuary, CMS, cms.gov, Feb. 20, 2019.

Financial impact for hospitals

HOSPITALS' COST TO PROVIDE UNCOMPENSATED CARE (in billions)



AHA Annual Survey of Hospitals data, American Hospital Association, 2018 and 2019.
* 2018 data is preliminary.

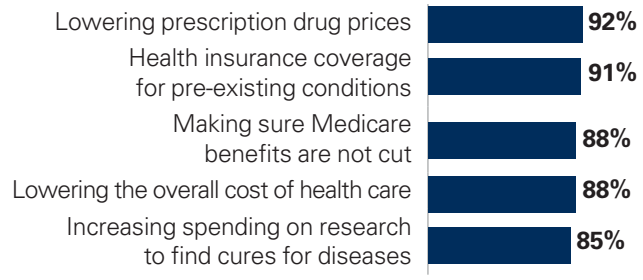
$76.6 BILLION

Combined Medicare and Medicaid underpayments to hospitals in 2018*

Patient perspective

69% Reducing health care costs should be a top national priority.

TOP HEALTH CARE PRIORITIES



Blendon, Robert J. et al. "The Upcoming U.S. Health Care Cost Debate — The Public's Views," *New England Journal of Medicine*, vol. 380 no. 26 (2019): 2487-2492.

OUT-OF-POCKET COSTS

- Out-of-pocket costs increased by 12% for inpatient, outpatient and ED care from 2017 to 2018*
- Medical fundraisers account for 1 in 3 campaigns for the crowdsourcing website GoFundMe.†

* "Out-of-Pocket Costs Rising Even as Patients Transition to Lower Cost Settings of Care," TransUnion Healthcare, June 25, 2019.
† Zdechlik, Mark. "Patients Are Turning To GoFundMe To Fill Health Insurance Gaps," National Public Radio, npr.org, Dec. 27, 2018.

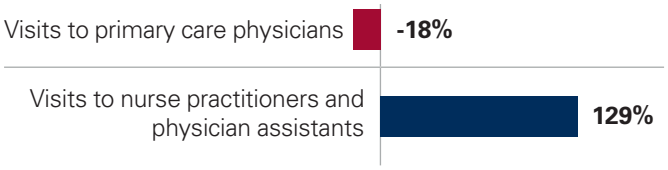
Employer-sponsored plans

INDIVIDUALS ENROLLED IN EMPLOYER-SPONSORED PLANS

- Half of Americans say they or an immediate family member have put off going to the doctor, not filled a prescription or delayed other medical care because of cost.*
- Four in 10 had difficulty paying a medical bill or insurance premium within the past year.†
- Four in 10 enrolled in a high-deductible plan do not have enough savings to cover the deductible.†
- One in 5 say health care costs have used up all or most of their savings.†

* Martin, Rachel. "Employees Start To Feel The Squeeze Of High-Deductible Health Plans," National Public Radio, npr.org, May 3, 2019.
† Levey, Noam N. "Health insurance deductibles soar, leaving Americans with unaffordable bills," *Los Angeles Times*, May 2, 2019.

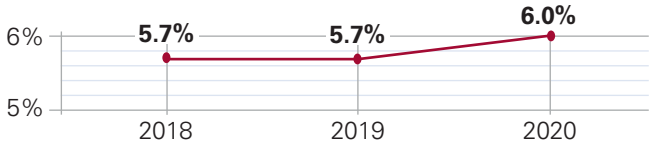
TRENDS AMONG CONSUMERS WITH EMPLOYER-SPONSORED INSURANCE FROM 2012 TO 2016



Frost, Amanda and Hargraves, John. "HCCI Brief: Trends in Primary Care Visits," Health Care Cost Institute, October 2018.

Medical cost trend

THE MEDICAL COSTS IN THE EMPLOYER INSURANCE MARKET PROJECTED TO INCREASE

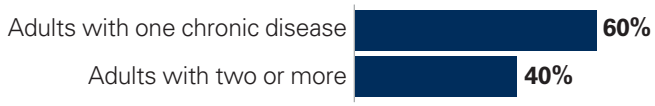


Drivers of medical cost trend

Retail drugs

Between 2020 and 2027, retail drug spending under private health insurance is projected to increase 3-6% a year.

Chronic disease

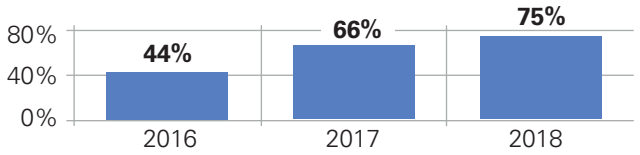


- For employers, per capita spending on an individual with a complex chronic disease is 8 times that of a healthy individual.

"Medical cost trend: Behind the numbers 2020," PWC Health Research Institute, June 2019.

Mental health services

PERCENTAGE OF EMPLOYERS OFFERING MENTAL HEALTH DISEASE-MANAGEMENT PROGRAMS



- Costs will go up in the short term. In the long term, addressing mental health is a significant deflator of medical cost trend.

"Medical cost trend: Behind the numbers 2020," PWC Health Research Institute, June 2019.

Employees bear the cost

- Average deductibles for employer-sponsored plans tripled between 2008 and 2018.*
- Average annual rate of cost sharing outpaced growth in wages from 2006 to 2016.*

- 84% of employers offered a High-Deductible Health Plan (HDHP) in 2019.*
- Enrollment in HDHPs reached 47% of the commercially insured, pre-Medicare population in 2018, representing a 3.3% increase from 2017.†

*"Medical cost trend: Behind the numbers 2020," PWC Health Research Institute, June 2019.
†Daly, Rich. "High-Deductible Plans Surge: CDC," Healthcare Financial Management Association, Aug. 28, 2018.

Prescription drugs

PRICES FOR MORE THAN 3,400 DRUGS INCREASED IN THE FIRST SIX MONTHS OF 2019

- An increase of 17% in the number of drug price increases.
- Average increase is 10.5% — five times the rate of inflation.

Picchi, Aimee. "Drug prices in 2019 are surging, with hikes at 5 times inflation," CBS News, cbsnews.com, July 1, 2019.

HOSPITAL PRESCRIPTION DRUG SPENDING

- Average total drug spending per hospital admission increased by 18.5% from 2015 to 2017.

"Recent Trends in Hospital Drug Spending and Manufacturer Shortages," NORC at the University of Chicago, Jan. 15, 2019.

MEDICARE AND MEDICAID DRUG SPENDING

From 2013 to 2017, prescription drug spending grew at an annual rate of 10.6% in Medicare Part D, 10.0% in Part B and 14.8% in Medicaid.

"CMS Updates Drug Dashboards with Prescription Drug Pricing and Spending Data," cms.gov, March 14, 2019.

PRESCRIPTION SPECIALTY DRUG COSTS IN 2017

$78,781 The average annual cost of prescription specialty drugs

vs.

$60,336 The median U.S. household income

7.0% Increase in cost vs. 2016

vs.

2.1% General rate of inflation

Schondelmeyer, Stephen W. and Purvis, Leigh. "Trends in Retail Prices of Specialty Prescription Drugs Widely Used by Older Americans: 2017 Year-End Update," AARP Public Policy Institute, June 2019.

Drug shortages

- Cost hospitals $359 million a year in additional labor costs.
- More than half of hospitals reported they had managed at least 20 shortages during a six-month period.

Vizient, Inc. Survey, "Drug shortages and labor costs, Measuring the hidden costs of drug shortages on U.S. hospitals," Vizient, Inc., June 2019.

Learn More at AHA.ORG

Learn more about AHA's The Value Initiative at **aha.org/value-initiative**

Advanced illness and palliative care

- Advanced illness accounts for 4% of the Medicare population and 25% of its costs.*
- 12 million U.S. adults and 400,000 children are living with serious illness.†
- 72% of hospitals with 50+ beds have a palliative care program.†

PALLIATIVE CARE IMPACT

$3.5 BILLION per year savings if hospitals nationwide implement high-quality palliative programs

66% reduction in symptom distress reported by palliative care patients

* Stuart, Brad et al. "A Large-Scale Advanced Illness Intervention Informs Medicare's New Serious Illness Payment Model," *Health Affairs*, vol. 38, no. 6 (2019): 950-956.
† "Changing how we think about palliative care," American Hospital Association, aha.org/palcare. Accessed Aug. 9, 2019.

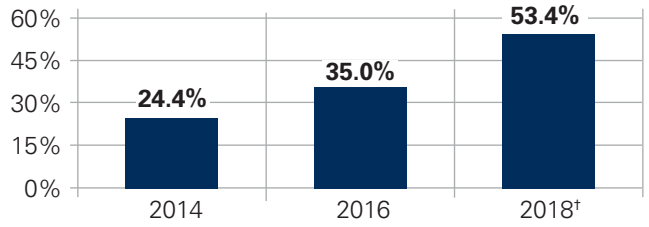
Learn More at AHA.ORG

Learn more about the AHA partnership with the Center to Advance Palliative Care: **aha.org/palcare**

CARE MODELS

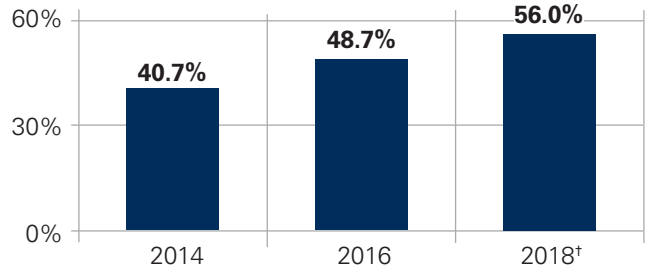
Trends in delivery models

HOSPITALS PARTICIPATING IN AN ACCOUNTABLE CARE ORGANIZATION (ACO)*

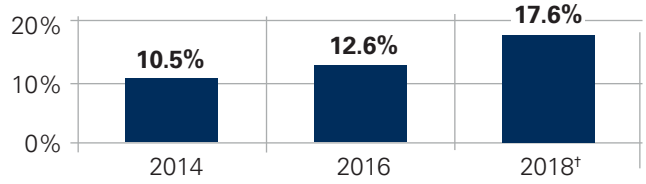


NOTE: 2018 survey question is not directly comparable to prior years.

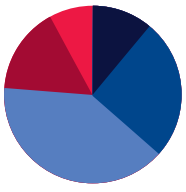
HOSPITALS WITH CONTRACTS WITH COMMERCIAL PAYERS TIED TO QUALITY/SAFETY PERFORMANCE*



HOSPITALS WITH SOME PERCENTAGE OF NET PATIENT REVENUE PAID ON A SHARED RISK BASIS*



HEALTH CARE LEADERS THINK VALUE-BASED RELATIONSHIPS THAT CONTAIN BOTH UPSIDE AND DOWNSIDE RISK WILL OCCUR‡



Less than 1 year	9.7%
1-2 years	26.7%
3-5 years	39.8%
5 or more years	17.5%
Never	6.3%

- Obstacles to shared-risk, value-based contracts: limitations in data sharing, no agreement on outcomes measures and a lack of incentives for payers and providers to work together

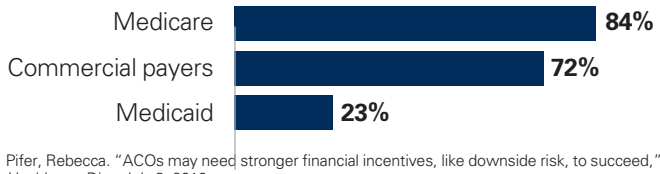
* AHA Annual Survey of Hospitals data, American Hospital Association 2015-2019.
† 2018 data is preliminary.
‡ "White Paper: The 9th Annual Industry Pulse Survey," Change Healthcare and the HealthCare Executive Group, March 18, 2019.

ACOs

ACOs BY THE NUMBERS

- The number of ACOs has multiplied 5 times since 2012.
- At the end of the first quarter of 2018, there were more than 1,000 ACOs across the U.S., covering 33 million lives and representing almost 1,500 commercial and public payment arrangements.
- 33% of ACOs had at least one contract with downside risk.

IN 2018, ACOs CONTRACTED WITH:



Pifer, Rebecca. "ACOs may need stronger financial incentives, like downside risk, to succeed," *Healthcare Dive*, July 3, 2019.

$740 MILLION Net savings generated by Medicare ACOs in 2018.

Verma, Seema. "Interest In 'Pathways To Success Grows: 2018 ACO Results Show Trends Supporting Program Redesign Continue," *HealthAffairs* blog, Sept. 30, 2019.

Top ACO priorities

TOP 5 PRIORITIES OF INTEGRATED SYSTEM/ HOSPITAL-LED ACOs

Reduce avoidable emergency department visits and inpatient admissions	57%
Manage post-acute care spending and quality	50%
Prevent readmissions through better care transitions	42%
Actively manage high-need, high-cost patients	37%
Reduce avoidable/unnecessary care	29%

TOP 5 CHALLENGES OF INTEGRATED SYSTEM/ HOSPITAL-LED ACOs

Difficulty aligning physician compensation with value-based contracts	63%
Ability to design and implement care delivery changes	57%
Quality of data provided by payers	36%
Lack of data analytic capability and tools	33%
Prospect of/participation in mandatory downside risk	22%

Edwards, Kerstin, et al. "The 2018 ACO Survey: Unique Paths to Success," Leavitt Partners, March 2019.

VALUE AND PERFORMANCE IMPROVEMENT

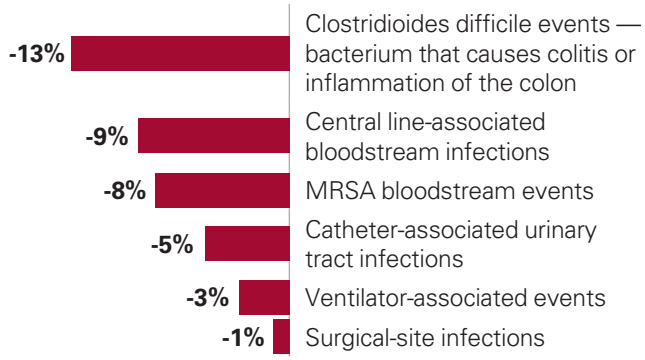
Performance improvement practices yield positive outcomes

HOSPITAL-ACQUIRED CONDITIONS: PROGRESS BETWEEN 2014 AND 2017

- 13% decrease in conditions
- 20,500 lives saved
- $7.7 billion saved in health care costs

"AHRQ National Scorecard on Hospital-Acquired Conditions," Agency for Healthcare Research and Quality, Rockville, Md. https://www.ahrq.gov/professionals/quality-patient-safety/pfp/index.html, January 2019.

PERCENTAGE DECREASE IN HOSPITAL-ACQUIRED INFECTIONS BETWEEN 2016 AND 2017 IN ACUTE CARE HOSPITALS



"2017 National and State Healthcare-Associated Infections Progress Report," Centers for Disease Control and Prevention, cdc.gov. Accessed July 28, 2019.

Top 5 patient safety concerns

- Diagnostic stewardship and test result management using EHRs
- Antimicrobial stewardship in physician practices and aging services
- Burnout and its impact on patient safety
- Patient safety concerns involving mobile health
- Reducing discomfort with behavioral health

"2019 Top 10 Patient Safety Concerns — Executive Brief," ECRI Institute, https://www.ecri.org/landing-top-10-patient-safety-concerns-2019. Accessed March 12, 2019.

Learn More at **AHA.ORG**

Learn more about how the AHA accelerates performance improvement and advances patient safety: **aha.org/center/performance-improvement**

American Hospital Association™ Advancing Health in America

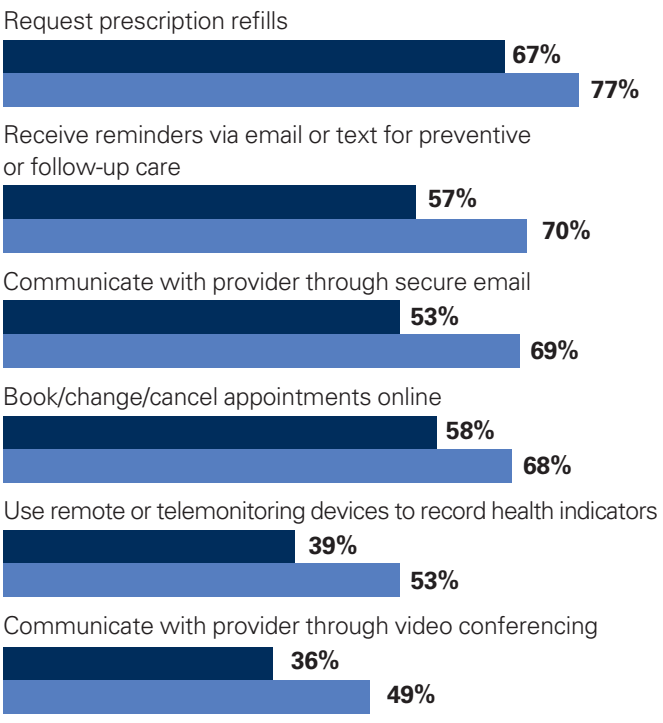
INDIVIDUAL AS PARTNER

Recognize the diversity of individuals and serve as partners in their health

Health care providers are fostering true patient engagement, recognizing that individuals are increasingly viewing health care through a consumer lens and connecting in ways that make sense in today's digital world.

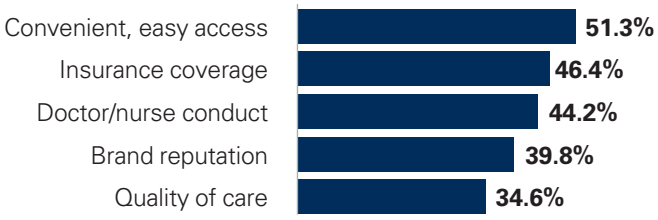
The consumer perspective

THE FOLLOWING ELECTRONIC CAPABILITIES INCREASE THE LIKELIHOOD OF AN INDIVIDUAL CHOOSING A PROVIDER:



Safavi, Kaveh and Kalis, Brian. "Today's Consumers Reveal the Future of Healthcare: The Accenture 2019 Digital Health Consumer Survey," Accenture, Feb. 12, 2019.

MOST IMPORTANT HEALTH CARE FACTORS INFLUENCING CONSUMERS' DECISION-MAKING

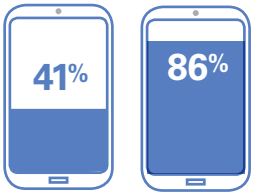


"2019 Healthcare Consumer Trends Report," NRC Health, Jan. 6, 2019.

Virtual care

Interest in virtual care is higher among consumers with more complex needs.*

EMPLOYERS OFFERING TELEHEALTH SERVICES†



61% of employers set employee cost-sharing lower for telemedicine visits than in-person visits in 2019.

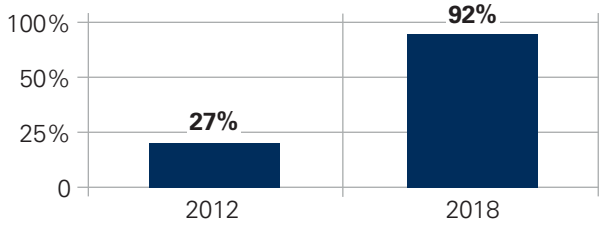
CONSUMERS WITH EMPLOYER COVERAGE ARE WILLING TO USE TELEHEALTH FOR:†

Ongoing assessment of a physical condition or ailment	**62%**
Initial assessment of a physical condition or ailment	**43%**
Mental/behavioral health services	**27%**
Emergency situations, such as urgent care	**25%**

* Safavi, Kaveh and Kalis, Brian. "Today's Consumers Reveal the Future of Healthcare: The Accenture 2019 Digital Health Consumer Survey," Accenture, Feb. 12, 2019.
† "Medical cost trend: Behind the numbers 2020," PWC Health Research Institute, June 2019.

Online Access

PERCENTAGE OF HOSPITALS THAT PROVIDE PATIENTS WITH THE ABILITY TO VIEW HEALTH INFORMATION ONLINE

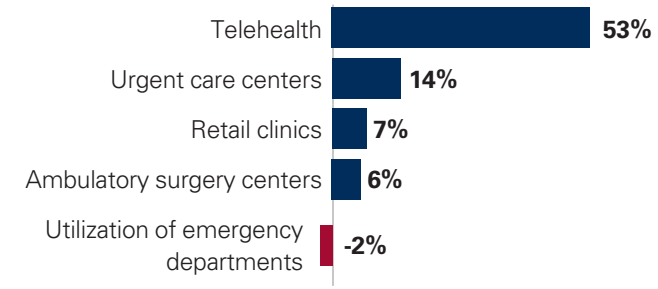


AHA Annual Survey Information Technology Supplement, American Hospital Association, 2018.

American Hospital Association™
Advancing Health in America

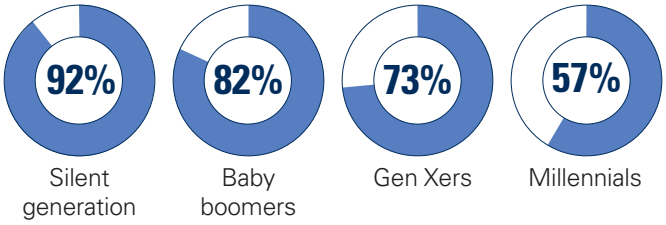
Alternative places of health care services: Consumer trends

UTILIZATION GROWTH RATES FROM 2016 TO 2017 ACCORDING TO PRIVATELY INSURED HEALTH CARE CLAIMS DATA



"FH Healthcare Indicators® and FH Medical Price Index® 2019: An Annual View of Place of Service Trends and Medical Pricing," White Paper, FAIR Health®, Inc., April 2019.

Who has a primary care physician?



MacCracken, Linda and Meklaus, Gerry. "Digital Health: When Primary Care is not Always Primary," Accenture, Sept. 19, 2018.

LGBTQ disparities

- 16% of people who identify as lesbian, gay, bisexual, trans, queer/questioning (LGBTQ) report being personally discriminated against when going to a doctor or health clinic because they are part of the LGBTQ community.*
- 18% of people who identify as LGBTQ say they have avoided medical care, even when in need, citing fear of discrimination.*
- High school students who identify as LGB are almost 5 times as likely to attempt suicide compared with their heterosexual peers.†
- Adults ages 50 to 95 who identify as LGBT reported greater rates of disability, depression and loneliness and increased likeliness to smoke and binge-drink compared with heterosexuals of similar ages.‡

* "Discrimination in America: Experiences and View of LGBTQ Americans," National Public Radio, Robert Wood Johnson Foundation and Harvard T.H. Chan School of Public Health, November 2017.
† LGBTQ, National Alliance on Mental Health, www.nami.org/find-support/lgbtq, Accessed Sept. 12, 2019.
‡ Seegert, Liz, "National study finds LGBT seniors face tougher old age," Association of Health Care Journalists, July 18, 2018.

Learn More at AHA.ORG

Learn more about the AHA's Institute for Diversity and Health Equity: **diversityconnection.org**

IMPACT AND LANDSCAPE OF HOSPITALS AND HEALTH SYSTEMS

Hospitals and health systems serve patients and communities as critical access points of health care services across the country.

Health care and the economy

11% of all jobs in the overall U.S. economy at the end of 2018 were in the health care sector.*

1 in 7 new jobs in the overall U.S. economy at the end of 2018 were in the health care sector.*

2.8 MILLION Number of jobs added to the health care sector between 2006 and 2016, a rate of growth almost 7 times faster than the rest of the economy†

Projections

- Employment of health care occupations is projected to grow 18% from 2016 to 2026, much faster than the average for all occupations, adding about 2.4 million new jobs.†
- Job growth in the home health field is projected to grow 54% from 2016 to 2026.‡

* Commins, John. "Healthcare Job Growth Outpaced Nearly Every Other Sector in 2018," *HealthLeaders*, Jan. 4, 2019.
† Salsberg, Edward and Martiniano, Robert. "Health Care Jobs Projected To Continue To Grow Far Faster Than Jobs In The General Economy," *Health Affairs*, May 9, 2018.
‡ "Occupational Outlook Handbook," Department of Labor, Bureau of Labor Statistics. Accessed Aug. 13, 2019.

American Hospital Association™
Advancing Health in America

Hospital prices

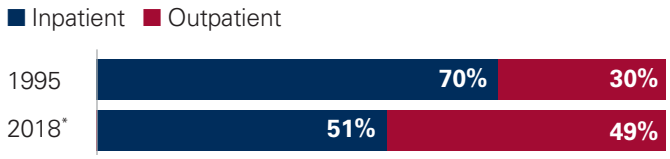
HOSPITAL PRICE GROWTH REMAINS LOW

In August 2019, annual health insurance inflation hit a five-year peak of 18.6%, while hospital prices increased just 2.1%.

Bureau of Labor Statistics Consumer Price Index data, 2019.

Community hospitals

INPATIENT/OUTPATIENT REVENUES FOR COMMUNITY HOSPITALS

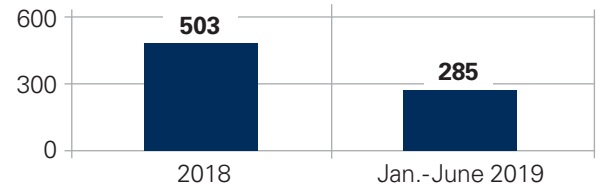


AHA Annual Survey of Hospitals data, American Hospital Association, 1996-2019.
*2018 data is preliminary.

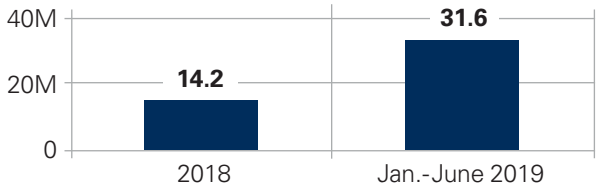
Cybersecurity

Health care cyber incidents

NUMBER OF U.S. HEALTH CARE DATA BREACHES



NUMBER OF PATIENT RECORDS AFFECTED
(in millions)



FROM JANUARY THROUGH JUNE 2019:

- External hacking was responsible for 88% of breached records.
- 72% of incidents occurred in the provider setting.
- Incidents involving business associates/third parties affected 74% of total patient records.

"Protenus 2019 Mid-Year Breach Barometer, Breached Patient Records in First Half of 2019 Double the Total for All of 2018," Protenus, Inc. in collaboration with DataBreaches.net, July 2019.

Learn More at AHA.ORG

Learn more about AHA cybersecurity and risk resources and services: **aha.org/cyberrisk**

The rural landscape

Rural hospitals at risk

- According to a study of hospital closure impacts, rural closures were associated with a 5.9% increase in inpatient mortality.*

AS OF SEPTEMBER 2019†

- 118 rural hospitals have closed since January 2010.
- 17 hospitals closed in 2019 alone, outpacing previous years.

* Gujral, Kritee, et al. "Impact of Rural and Urban Hospital Closures on Inpatient Mortality," Working Paper Series, National Bureau of Economic Research, July 22, 2019.
† The Cecil G. Sheps Center for Health Services Research, University of North Carolina, shepscenter.unc.edu. Accessed Oct. 10, 2019.

Rural health care workforce shortages

- While almost 20% of the U.S. population lives in rural areas, less than 10% of physicians practice in these communities.*

66% of primary care physician shortages in the U.S. in 2018 were located in rural or partially rural areas.†

62% of mental health professional shortages in the U.S. in 2018 were located in rural or partially rural areas.†

-23% Decrease in the supply of physicians in rural areas by 2030 while remaining steady in urban areas†

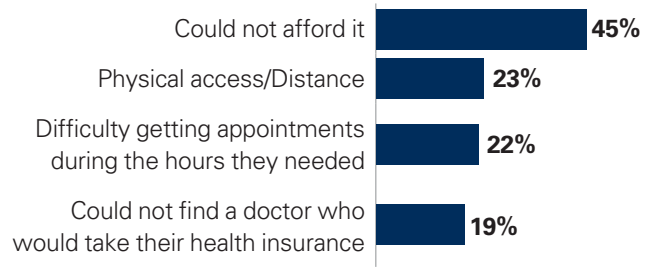
- In 2017, more than 50% of rural physicians were at least 50 years old and more than 25% were at least 60 years old.†

* Joynt E. Karen, et al. "Rural Hospital Participation and Performance in Value-Based Purchasing and Other Delivery System Reform Initiatives," ASPE Office of Health Policy, October 19, 2016.
† Skinner, Lucy, et al., "Implications of an Aging Rural Physician Workforce," *New England Journal of Medicine*, 2019; 381:299-301.

Health care access in rural America

- 42% of rural adults without health insurance reported they did not get care when they needed it, while 24% of those with health insurance did not get care when they needed it.

REASONS FOR NOT GETTING CARE



"Life in Rural America, Part II," National Public Radio, Robert Wood Johnson Foundation and Harvard T.H. Chan School of Public Health, May 1, 2019.

Learn More at AHA.ORG

Learn more about AHA rural health resources: **aha.org/rural**

AHA Agenda for Innovation and Transformation

The AHA continually examines the environment to develop strategies that both address the issues of today and proactively prepare our field for the future. The AHA's Agenda for Innovation and Transformation advances the areas of public policy, field engagement and innovation to enhance our support, value and leadership for members. Maryjane Wurth is responsible for AHA's overall strategic direction and is the lead executive for the AHA Center for Health Innovation.

Q&A

MARYJANE WURTH

Executive Vice President and Chief Operating Officer of the American Hospital Association

QUESTION: Hospitals and health systems are investing in innovation to address access, affordability and outcomes. What role does the AHA play in assisting and encouraging innovative culture, processes and solutions throughout the hospital field?

WURTH: Over a year ago, we launched the AHA Center for Health Innovation to help members drive high-impact innovation and transformation within their organizations and communities. The Center provides market intelligence, key insights, targeted education and actionable data and tools that support the unique situations of our members. One goal is to help hospitals and health systems build innovation capacity within their institutions.

Additionally, the AHA is uniquely positioned to provide a national perspective on forward-looking ideas and solutions, helping members learn from each other as well as traditional and nontraditional stakeholders. Examples include the AHA's work with more than 1,600 hospitals in the Hospital Improvement Innovation Network, efforts to address affordability through The Value Initiative, creation of a data collaborative with state hospital associations, exploration of new delivery models and development of resources to support population health management.

We're taking the work of spreading ideas and best practices to the next level. We are developing a process to scale transformation throughout the field through the Center's new virtual entity called the Design Studio, created in partnership with members, that focuses on advancing the next-generation health care system.

QUESTION: Can you tell us more about the AHA Design Studio? How is it different from hospital and health system innovation centers?

WURTH: The purpose of the Design Studio is to accelerate and lead transformation, addressing complex challenges in the field with unique member collaborations. The Design Studio will not duplicate what hospitals and systems are doing in their labs. The goal is to harness hospitals' and health systems' collaborative energy to discover novel solutions that would be much more challenging, or perhaps impossible, to develop alone.

The work in the Design Studio is based on a human-centered design approach. As the virtual studio 'rooms' progress, the design teams may take different paths and employ unique approaches. The Design Studio will emphasize issues that matter to our members and will rely on their input, engagement and enthusiasm. Our initial areas of focus, supported by the AHA's Board of Trustees, are behavioral health, EHR data usability and risk approaches.

A key outcome of the Design Studio will be the spread of curated learnings to all members throughout the design process. Other outcomes could include transformational partnerships, products, resources or tools or other outcomes we have yet to imagine. Our journey may take surprising turns. All together, the Design Studio ideas, solutions and results will drive value to address affordability and better health for patients, families and communities.

Innovation

2019 AHA CHAIR-ELECT

Melinda L. Estes, M.D.
President and CEO, Saint Luke's Health System

"Innovation is not just a buzz word — it is a shift in mindset and culture that allows for both continual improvement and transformative ideas to develop from all stakeholders within hospitals and health systems. The digital health evolution plays an important role; however, both high-tech and high-touch solutions are needed to solve our most difficult challenges. A starting point for innovation is to truly listen to and understand the needs of our patients and communities."

Next-gen leaders

2019 AHA CHAIR

Brian Gragnolati
President and CEO, Atlantic Health System

"I am optimistic about health care's future because emerging leaders in our field have the passion for improving the health of patients and populations and have an inspirational vision for a reimagined health system. They understand that health care is a team sport, and teams are more diverse and multigenerational than ever before. High-functioning teams that are empowered can express empathy, embrace change, solve problems and improve the health care experience for all."

Affordability

2019 AHA IMMEDIATE PAST CHAIR

Nancy Howell Agee
President and CEO, Carilion Clinic

"Affordability is one of the most important factors influencing Americans' ability to access care. The AHA recognizes that addressing the out-of-pocket costs for our patients needs to be a key focus of our efforts. From redesigning delivery and payment systems, to implementing operational solutions and investing in innovation, the hospital field is making changes to increase value, improve outcomes and reduce costs. And we are working to influence other stakeholders to do the same."

How to use the 2020 AHA Environmental Scan

- **Share with your board and staff at meetings and retreats.** Ask: What two or three pieces of information concern or surprise you the most? What are the implications for our patients and our community? If we were reinventing the health care system from scratch, what kind of system would we create to respond to these issues?
- **Use the information to tell your story to the community you serve.** Identify vehicles for these communications, such as presentations, reports, op-eds and material you share with legislators and funders. Post relevant information to your website and link to the entire Environmental Scan at **aha.org/environmentalscan**.
- **Talk with your strategy team** about the implications on your strategic plan, partnerships and business development strategy. Identify possible disruptions to your organization's business model. Use the scan data and themes in a SWOT analysis (strengths, weaknesses, opportunities and threats).
- **Talk with your chief innovation officer and chief financial officer** about the implications for your investment in innovation.
- **Perform competitive analyses and gather intelligence** to understand what existing or potential competitors might be planning around these trends.

Learn More at **AHA.ORG**

Continue exploring AHA's market intelligence, strategy and data resources on a regular basis to bring fresh issues and data to your teams. Resources include:

- AHA Data: **ahadata.com**
- AHA Market Scan e-newsletter: **aha.org/marketscan**
- AHA Market Insight reports: **aha.org/marketinsights**
- Futurescan 2020-2025, a publication exploring key issues that are transforming the field: **shsmd.org/futurescan**
- Learn about additional AHA tools and resources to help you Scan and Plan throughout the year: **aha.org/scanandplan**

BESmith.com
855.296.6318

B.E. SMITH®
an AMN Healthcare company

4 PILLARS TO BUILD LEADERSHIP STRENGTH

Organizations must simultaneously pursue strategies in these four areas to build strong leadership. Discover what insights are influencing the healthcare workforce.

RETENTION

40% HAVE A FORMAL SYSTEM FOR IDENTIFYING HIGH-PERFORMING LEADERS

45% HAVE STRATEGIES TO RETAIN TOP PERFORMERS

PREFERRED METHOD OF RECRUITING

37% REFERRALS

22% WEBSITE

INFLUENTIAL FACTORS TO RETAINING TOP TALENT

27% SUCCESSION PLANNING

27% BENEFITS / COMPENSATION

ENGAGEMENT

WAYS ENGAGEMENT IS MEASURED

72% EFFECT ON PATIENT SATISFACTION

54% OPERATIONAL MEASURES

46% FINANCES

RECRUITMENT

44% PLAN TO INCREASE RECRUITMENT OF PASSIVE CANDIDATES

43% SAY DIVERSITY IS A PRIMARY RECRUITMENT FOCUS

LEADERSHIP DEVELOPMENT

CURRENT PROGRAMS

64% FORMAL LEADERSHIP INSTITUTE

64% MENTORING

60% ORGANIZATIONAL PLANNING

B.E. SMITH: MATCHING LEADERS WITH ORGANIZATIONS

B.E. Smith supports leadership needs ranging from permanent and interim placements to advisory services - covering all clinical, operational, and financial areas of care delivery.
Visit www.BESmith.com or call 855.296.6318 for more information.

2019 REPORT ON LEGISLATION

CALIFORNIA HOSPITAL ASSOCIATION

Hospital Council Northern & Central California

HOSPITAL ASSOCIATION OF SOUTHERN CALIFORNIA

HOSPITAL ASSOCIATION of San Diego & Imperial Counties

Table of Contents

President & CEO Message

The California Hospital Association's 2019 *Report on Legislation* summarizes the year's most significant health care-related bills and serves as a reference tool to help hospitals comply with new laws. This report should be shared with your leadership team so they can take any necessary steps to implement new requirements.

Despite a supermajority of Democrats in the Legislature and a new Governor, this was a successful year for California hospitals. We secured important gains in health care coverage and access, and buffered hospitals from the full impact of onerous regulations.

Among 2019's key achievements were:

• Halting momentum on a bill that would have, in an effort to ban surprise billing, set rates for insurance companies to pay hospitals for out-of-network emergency care

• Advancing a bill to offer relief from the state's outdated 2030 hospital seismic standards and help ensure uninterrupted care following a disaster; at our request, that bill has been extended into next year so we can continue to educate lawmakers

• Punching a big hole in the nurse staffing ratio penalties bill, giving hospitals flexibility to meet ratios when encountering "unpredictable" and "uncontrollable" circumstances, and removing a prescriptive mandate on how hospitals should attempt to fill vacant spots

• Defeating a bill that would have expanded workers' compensation by creating a presumption that workers were injured on the job if they were diagnosed with certain illnesses — cancer, asthma, and others — unless the hospital could prove the employee *did not* contract the illness or injury at work

• Increasing investments in behavioral health — leveraging our awareness-raising work with the CHA co-led coalition Behavioral Health Action — including $150 million for mental health workforce development (some of which can be used directly in emergency departments), $100 million for whole person care pilot programs, $70 million for Medi-Cal integration programs, and more

We also supported a bill that aims to reduce racial disparities in maternal health and, through the state budget process, advanced other key priorities, including expanded Medi-Cal coverage and insurance subsidies.

Next year will be the second year of the Legislature's current two-year session, and more challenges await. We'll be meeting with legislators to help them understand what hospitals do for their patients and communities, and to advocate for policies that foster an environment where hospitals can thrive.

We know that success is only possible with the support of our members — along with the Regional Associations, constituency groups, allied organizations, hospital trustees, CEOs, volunteers, employees, and others. Thank you for lending your voice in support of our work to help hospitals throughout California.

Carmela Coyle, *President & CEO*

New Laws With High Impact

Among the many health care-related laws enacted this year are a few that impact overall hospital operations or necessitate significant attention as they move toward implementation in January. Following are those laws, which hospital leaders may want to share with key members of their teams.

Employees and independent contractors

***AB 5* (Gonzalez, D-San Diego)** ●

Codifies the *Dynamex* decision, which adopted an "ABC" test for determining independent contractor status. Substantially limits the use of independent contractors and adopts a limited business-to-business provision that could adversely affect health care staffing agreements and contracts.

Nurse staffing ratio penalties

***SB 227* (Leyva, D-Chino)** ■

Requires the California Department of Public Health (CDPH) to impose administrative penalties of $15,000 or $30,000 for violations of nurse-to-patient staffing ratios. The bill was amended to allow CDPH to consider, prior to issuing a fine, if a hospital's fluctuation in required staffing levels was "unpredictable" and "uncontrollable;" if prompt efforts were made to maintain required staffing levels; and if, in making those efforts, the hospital immediately utilized its on-call list of nurses and the charge nurse.

Procurement contracts

***AB 962* (Burke, D-Inglewood)** ● ●

Requires hospitals with operating expenses of at least $50 million — or, if they are part of a system of hospitals, at least $25 million — to submit a report after July 1, 2021, to the Office of Statewide Health Planning and Development (OSHPD) on their minority, women, lesbian, gay, bisexual, transgender, and disabled veteran-owned business enterprise procurement efforts. Requires OSHPD to post the reports on its website, and to convene a hospital diversity commission to advise and provide recommendations on the best methods to increase procurement with diverse suppliers within hospitals.

Maternal health

***SB 464* (Mitchell, D-Los Angeles)** ● ●

Requires hospitals — as well as alternative birthing centers and specified primary care clinics — that provide perinatal care to implement an implicit bias program for all employed perinatal care providers. Each perinatal care provider must complete initial basic training and a refresher course every two years. The facility must also offer the training to physicians who treat perinatal patients but are not employed by the facility. This bill also requires hospitals to report on severe maternal morbidity and pregnancy-related deaths.

Medical laboratory technician training

***SB 334* (Pan, D-Sacramento)** ■

Requires the California Department of Public Health (CDPH) to establish a pathway program, by 2022, allowing medical laboratory technicians (MLTs) to apply their work experience and training from a CDPH-approved MLT training program toward completion of a clinical lab scientist (CLS) training program, removing redundancy and reducing the time required for an MLT to become a licensed CLS — a profession currently experiencing critical shortages.

Telehealth coverage

***AB 744* (Aguiar-Curry, D-Winters)** ■

Requires health plan and insurer policies issued, amended, or renewed on or after Jan. 1, 2021, to cover telehealth services on the same basis and to the same extent as the same service provided in person. Eases Medi-Cal telehealth restrictions.

Legislative Summary

Following are brief descriptions of bills enacted during the first year of the 2019-20 legislative session that directly impact hospitals. The full text of each new law is available at http://leginfo.legislature.ca.gov/. Each measure is categorized by subject, alphabetically, and indicates which hospital team members should take necessary steps to come into compliance (see legend at bottom of each page). In addition, the laws are indexed by author, bill number, and staff role. Urgency bills include the date they became effective. All other measures will take effect Jan. 1, 2020.

State Budget

This year's budget

• Expands Medi-Cal coverage to all income-eligible undocumented young adults ages 19 through 25 and provides health insurance premium support for individuals earning up to 600% of the federal poverty level. The premium assistance is funded in part by restoration of an individual mandate.

• Extends Medi-Cal coverage for low-income women diagnosed with postpartum depression from two months to 12 months post-birth.

• Recognizes the importance of mental health supports in the fight against homelessness and includes a $1 billion investment for emergency housing vouchers and shelter construction. It expands whole person care, including wraparound health, behavioral health, and housing services focused on people experiencing homelessness. It also dedicates significant funding to address the shortage of mental health professionals in the public mental health system.

• Includes a one-time, $20 million General Fund expenditure for hospitals to hire trained behavioral health counselors in acute care hospital emergency departments, to screen patients and offer intervention and referrals to mental health or substance use disorder programs.

• Includes a one-time $50 million General Fund expenditure to increase training opportunities in mental health workforce programs administered by the Office of Statewide Health Planning and Development. This funding includes $2.65 million for a primary care clinician psychiatry fellowship program and $1 million for mental health professionals formerly in the foster care system.

• Allocates a one-time $35 million General Fund expenditure and a one-time $25 million Mental Health Services Fund expenditure to implement the new 2020-25 Workforce Education and Training five-year plan.

• In addition, two months after the budget passed, the Governor signed AB 115 (Chapter 348, Statutes of 2019), a health budget trailer bill for 2019-20, to continue a managed care organization provider tax, effective July 1, 2019. Contingent upon federal approval, the tax will be in effect through Dec. 31, 2022.

Clinical Laboratories

Medical laboratory technician training

▶***SB 334* (Pan, D-Sacramento)** ■

Requires the California Department of Public Health (CDPH) to establish a pathway program, by 2022, allowing medical laboratory technicians (MLTs) to apply their work experience and training from a CDPH-approved MLT training program toward completion of a clinical lab scientist (CLS) training program, removing redundancy and reducing the time required for an MLT to become a licensed CLS — a profession currently experiencing critical shortages.

Community Benefits

Revised hospital community benefits reporting

▶***AB 204* (Wood, D-Santa Rosa)** ■ ●

Requires hospitals to report on community benefits at the hospital level rather than the system level. Permits hospitals on a consolidated license to file a consolidated community benefit plan report if they serve the same geographic area. Requires each hospital's community benefit report to contain a description of how the identified needs are being addressed and an explanation of the methodology used to determine their costs. Authorizes the Office of Statewide Health Planning and Development to impose fines not to exceed $5,000 on hospitals that fail to adopt, update, or submit community benefit plans.

Emergency Services

Air ambulance services

▶***AB 651* (Grayson, D-Concord)** ■

Limits an enrollee's or insured's cost-sharing for out-of-network air ambulance services to the amount that would apply for the same services received from a contracted air ambulance provider. Extends the termination date of the Vehicle Code penalty assessment, known as the supplemental Emergency Medical Air Transportation Act, to July 1, 2020.

Paradise emergency stabilization services

▶***SB 156* (Nielsen, R-Red Bluff)** ■

Requires the California Department of Public Health to issue a special permit to a hospital to offer emergency stabilization services at the site of the former Feather River Hospital in Paradise for up to six years, if certain requirements are met.

Employment

Employees and independent contractors

▶***AB 5* (Gonzalez, D-San Diego)** ●

Codifies the *Dynamex* decision, which adopted an "ABC" test for determining independent contractor status. Substantially limits the use of independent contractors and adopts a limited business-to-business provision that could adversely affect health care staffing agreements and contracts.

Mandatory leave

▶***AB 1223* (Arambula, D-Fresno)** ●

Provides a second unpaid 30-day leave of absence for organ donors who work for private employers, the State of California, and the California State University system.

Discrimination: Hairstyles

▶***SB 188* (Mitchell, D-Los Angeles)** ●

For purposes of California anti-discrimination law, prohibits racial discrimination based on traits historically associated with race, including, but not limited to, hair texture and protective hairstyles, such as braids, locks, and twists.

Nurse staffing ratio penalties

▶***SB 227* (Leyva, D-Chino)** ■

Requires the California Department of Public Health (CDPH) to impose administrative penalties of $15,000 or $30,000 for violations of nurse-to-patient staffing ratios. The bill was amended to allow CDPH to consider, prior to issuing a fine, if a hospital's fluctuation in required staffing levels was "unpredictable" and "uncontrollable;" if prompt efforts were made to maintain required staffing levels; and if, in making those efforts, the hospital immediately utilized its on-call list of nurses and the charge nurse.

Inspections: Employee rights

▶***SB 322* (Bradford, D-Gardena)** ■ ●

Reaffirms that an employee or employee representative has the right to privately discuss possible regulatory violations or patient safety concerns with a California Department of Public Health surveyor during the course of an investigation or inspection by the department.

Sexual harassment training requirements

▶***SB 778* (Senate Committee on Labor, Public Employment and Retirement)** ●

Extends the deadline for providing sexual harassment prevention training to Dec. 31, 2020, and allows employers that have provided anti-harassment training between Jan. 1, 2019, and Dec. 31, 2020, to maintain their existing biannual training schedule.

Health Care Coverage

Third-party payments

▶***AB 290* (Wood, D-Santa Rosa)** ■ ●

Limits reimbursement rates to health care providers that pay a health plan or insurance premium for a patient, and places additional requirements on these providers.

Long-Term Care Insurance Task Force

▶***AB 567* (Calderon, D-Whittier)** ■

Establishes the Long-Term Care Insurance Task Force within the Department of Insurance to recommend options for a statewide long-term care insurance program.

Rate review filing requirements

▶***AB 731* (Kalra, D-San Jose)** ■ ●

Expands rate review filing requirements for large-group health plan and health insurance policies. Requires the Department of Managed Health Care and the Department of Insurance to determine if large-group community rate changes are unreasonable or unjustified and, if so, requires health plans and insurers to notify the purchaser.

Extension of open enrollment deadline

▶ ***AB 1309* (Bauer-Kahan, D-Orinda)** ■

Extends — from Jan. 15 to Jan. 31 — the open enrollment deadline for purchasing individual insurance coverage through Covered California or off-exchange.

Enrollment in automatic health care coverage

▶ ***SB 260* (Hurtado, D-Sanger)** ■

Requires health plans and insurers to annually notify individuals that 1) when they cease to be enrolled in coverage, their contact information will be provided to Covered California to help them obtain other coverage, and 2) they may opt out of this transfer of information. Beginning July 1, 2021, requires Covered California to enroll individuals using electronic information from Medi-Cal or the Children's Health Insurance Program in the lowest-cost silver Covered California plan.

Medical supplemental insurance extension

▶ ***SB 407* (Monning, D-Carmel)** ■

Extends the Medicare supplemental insurance — or "Medigap" — annual open enrollment period by 30 additional days (for a total of 60 days or more), beginning with the individual's birthday. Requires an issuer of a Medicare supplemental policy with new or innovative benefits to identify the portion of the premium attributed to the new or innovative benefits as a separate line item on the payment or invoice. Requires the Department of Managed Health Care and the Department of Insurance to collaborate on policies and procedures that standardize new or innovative benefits so that consumers can compare benefits, out-of-pocket costs, and premiums.

Clinical trials

▶ ***SB 583* (Jackson, D-Santa Barbara)** ■

Requires health plans and insurers to cover clinical trials relating to the prevention, detection, or treatment of a life-threatening disease or condition to conform with the Affordable Care Act.

Homelessness

Homeless multidisciplinary teams

▶ ***AB 728* (Santiago, D-Los Angeles)** ● ■

Establishes, until Jan. 1, 2025, a pilot program in the counties of Los Angeles, Orange, Riverside, San Bernardino, San Diego, Santa Clara, and Ventura that aims to prevent homelessness by allowing multidisciplinary teams to expedite identification, assessment, and linkage of individuals at risk of homelessness to housing and supportive services.

Medi-Cal

Podiatric services

▶ ***AB 678* (Flora, R-Ripon)** ■ ■

Prohibits Medi-Cal from requiring podiatrists to submit a prior authorization if a physician providing the same service would not have to submit one. Also subjects podiatrists to the same Medi-Cal billing and services policies as physicians.

Pediatric health care services

▶***AB 781* (Maienschein, D-San Diego)** ■

Requires Medi-Cal to cover pediatric day health care services at any time of the day and on any day of the week, as long as the total number of authorized hours is not exceeded, up to 23 hours per calendar day.

Eligibility

▶***AB 1088* (Wood, D-Santa Rosa)** ■

Requires the Department of Health Care Services to seek a Medicaid state plan amendment or waiver to implement an income disregard that would allow an aged, blind, or disabled individual who becomes ineligible for benefits under the Medi-Cal program because of the state's payment of the individual's Medicare Part B premiums (outpatient services) to remain eligible if their income and resources otherwise meet eligibility requirements.

Telehealth: State of emergency

▶***AB 1494* (Aguiar-Curry, D-Winters)** ■

Prohibits requiring face-to-face contact with Medi-Cal beneficiaries, or their physical presence, on the premises of a community clinic for services to be provided during or immediately following a state of emergency. Also requires the Department of Health Care Services — on or before July 1, 2020 — to issue guidance to facilitate reimbursement for services provided by community clinics to Medi-Cal beneficiaries during or immediately following a state of emergency.

Medi-Cal Public Provider Intergovernmental Transfer Program

▶***AB 1705* (Bonta, D-Alameda)** ■

Authorizes a new supplemental Medi-Cal Public Provider Intergovernmental Transfer Program for public ground emergency medical transportation providers that would provide additional payments to them in fee-for-service (FFS) Medi-Cal and Medi-Cal managed care plans. Replaces the existing certified public expenditures program used to fund FFS public ground providers.

Medical Staff

Martin Luther King Jr. Community Hospital licensing

▶***AB 1037* (Gipson, D-Carson)** ●

Allows Martin Luther King Jr. Community Hospital to establish a medical foundation with 26 licensed physicians (instead of the 40 otherwise required by the Health & Safety Code). Also exempts from licensure requirements a nonprofit clinic that provides health services solely within a ZIP code within six miles of Martin Luther King Jr. Community Hospital, and that meets certain other requirements.

Reports of abuse and misconduct

▶***SB 425* (Hill, D-San Mateo)** ● ●

Requires health facilities and health plans to notify the appropriate licensing board within 15 days of receiving a written allegation of sexual abuse or sexual misconduct against a physician, nurse, or other licensed health care professional.

Failure to notify the board is punishable by a fine of up to $50,000 per negligent violation and up to $100,000 per willful violation. Provides immunity from civil or criminal liability for notifying the board of the alleged sexual abuse or sexual misconduct.

Physician assistant practice agreements

▶***SB 697* (Caballero, D-Salinas)** ■ ●

Allows multiple physicians to supervise a physician assistant (PA); eliminates the statutory requirement of medical record review; and allows supervising physicians to determine the appropriate level of supervision for PA practice. Also clarifies that PAs can furnish or order a drug or device in accordance with the practice agreement, consistent with the PA's education and clinical training, and for Schedule II or III controlled substances, in accordance with the practice agreement or a patient-specific order approved by the treating or supervising physician; and makes various technical changes. For PAs practicing in general acute care hospitals, requires their supervising physicians to have privileges to practice in that hospital; the hospital must adopt a policy and procedure to identify a physician who is supervising the PA. Retains the ratio of 1:4 for physician supervision of PAs.

Patients' Rights

Required notice to patients

▶***AB 630* (Arambula, D-Fresno)** ●

Requires marriage and family therapists, educational psychologists, clinical social workers, and professional clinical counselors to give a written notice to each patient prior to providing services, informing the patient that the Board of Behavioral Sciences is responsible for complaints about these practitioners.

Program for All-Inclusive Care for the Elderly center

▶***AB 1128* (Petrie-Norris, D-Laguna Beach)** ●

Transfers from the Department of Public Health to the Department of Health Care Services the oversight and regulation of a primary care clinic, adult day health center, or home health agency that exclusively serves patients of a Program for All-Inclusive Care for the Elderly (PACE) organization.

Deaf and Disabled Telecommunications Program

▶***AB 1514* (Patterson, R-Fresno)** ●

Authorizes a nurse practitioner to certify the needs of an individual diagnosed as deaf or hard of hearing by a physician to participate in the California Deaf and Disabled Telecommunications Program (DDTP). DDTP is a universal service program that provides specialized telephone equipment and relay services to individuals who have difficulty using the telephone due to difficulties seeing, hearing, speaking, or remembering. The program is run by the California Public Utilities Commission.

Implementation of Master Plan for Aging

▶***SB 228* (Jackson, D-Santa Barbara)** ■

Requires the Secretary of the California Health and Human Services Agency to lead the development and implementation of the Master Plan for Aging, and to work with certain agencies to identify policies, efficiencies, and strategies necessary to implement the Master Plan.

Protection and advocacy agency

▶***SB 398* (Durazo, D-Los Angeles)** ●

Adopts changes that conform to federal law, regulation, and guidance as they relate to the state's protection and advocacy agency to ensure the rights and safety of individuals with disabilities. CHA negotiated certain changes to ensure the bill does not expand beyond federal requirements.

Pharmacy

Prescription forms

▶***AB 149* (Cooper, D-Elk Grove)** ■ ●

This urgency bill became effective March 11, 2019. It delays the requirement for controlled substance prescription forms to include a uniquely serialized number until a date determined by the Department of Justice, but no later than Jan. 1, 2020.

CURES database

▶***AB 528* (Low, D-Campbell)** ■ ● ●

Requires a pharmacy or other dispenser to report to the Controlled Substance Utilization Review and Evaluation System (CURES) database within one working day (instead of seven) after releasing a controlled substance to a patient; requires the dispensing of Schedule V substances to be reported; and requires prescribers to consult the CURES database every six months, rather than four, when renewing a prescription.

Opioid prescription drugs

▶***AB 714* (Wood, D-Santa Rosa)** ■ ● ●

Clarifies current law requiring prescribers to offer a prescription for naloxone hydrochloride by specifying that it applies only when an opioid is prescribed, or a benzodiazepine is prescribed within one year of dispensing an opioid. The bill also exempts inpatients and hospice patients from this requirement.

Standards for compounding drug preparations

▶***AB 973* (Irwin, D-Thousand Oaks)** ■ ● ●

Requires the compounding of drug preparations by a pharmacy to be consistent with standards established in the pharmacy compounding chapters of the current version of the United States Pharmacopeia-National Formulary, including relevant testing and quality assurance.

Claims for prescription services

▶***AB 1803* (Assembly Committee on Health)** ■ ●

Delays until Jan. 1, 2020, a requirement for a pharmacy to submit a claim to the health plan or insurer when the retail price for a covered prescription is lower than the patient's cost-sharing amount and the customer pays the retail price.

HIV prophylaxis

▶***SB 159* (Wiener, D-San Francisco)** ■ ●

Allows a specially trained pharmacist to furnish pre-exposure and post-exposure HIV prophylaxis. Also prohibits payers from subjecting antiretroviral drugs to prior authorization or step therapy, with some exceptions.

Prescriptions: Local, state, or federal emergencies

▶***SB 569* (Stone, R-La Quinta)** ■ ●

Allows a pharmacist to fill a prescription for a controlled substance for a patient who cannot access medications as a result of a declared local, state, or federal emergency, if the California Board of Pharmacy issues a waiver notice. The prescription does not need to meet the usual controlled substances prescription requirements but must say "11159.3 exemption" on it and meet other requirements.

Privacy and Personal Information

California Consumer Privacy Act

▶***AB 25* (Chau, D-Arcadia)** ●

Exempts from the California Consumer Privacy Act of 2018 (CCPA) personal information collected about a job applicant, employee, owner, director, officer, medical staff member, or contractor of a business until Jan. 1, 2021. However, during 2020, covered businesses will be required to inform these individuals about the categories of personal information collected about them. Businesses are also subject to lawsuits and statutory damages of $100-$750 for violating the duty to maintain reasonable information security practices for information collected about employees and others. CCPA does not apply to not-for-profit organizations.

Mandated reporters of child abuse or neglect

▶***AB 189* (Kamlager-Dove, D-Los Angeles)** ●

Adds autism service providers to the list of professionals who are mandated child abuse reporters.

Donor identification information

▶***AB 785* (Bloom, D-Santa Monica)** ●

Requires gamete banks to collect, maintain, and disclose certain information about donors and prohibits certain individuals from being listed on the birth certificate unless a voluntary declaration of parentage is signed.

Personal information

▶***AB 874* (Irwin, D-Thousand Oaks)** ●

Revises the California Consumer Privacy Act of 2018 (CCPA) to narrow the definition of "personal information" and exempt de-identified or aggregate information. CCPA does not apply to not-for-profit organizations.

Oocyte procurement

▶***AB 922* (Burke, D-Inglewood)** ●

Enacts the "Research Participants Undergoing Oocyte Retrieval for Medical Research Purposes Bill of Rights," to be given to patients as part of the process of obtaining informed consent. Also requires women who donate human oocytes for research to be compensated for their time, discomfort, and inconvenience as determined by a human subject research panel or institutional review board.

Collection of personal information

▶***AB 1355* (Chau, D-Arcadia)** ●

Exempts from certain provisions of the California Consumer Privacy Act of 2018 (CCPA) personal information collected during business-to-business communications until Jan. 1, 2021. CCPA does not apply to not-for-profit organizations.

Public Health

California Health Benefit Exchange: Data collection

▶***AB 929* (Luz Rivas, D-Arleta)** ■

Requires Covered California to post on its website any data received on cost reduction efforts, quality improvements, and disparity reductions from qualified health plans. Also requires qualified

health plans to report enrollee data and quality measures. Exempts from disclosure records that reveal specified claims, rate data, or patient-identifiable health information. Deletes an existing requirement that payment rates be disclosed three years after the contract period ends.

Medical exemptions for vaccinations

▶***SB 276* (Pan, D-Sacramento)** ●

California schools require children to be vaccinated unless medically contraindicated; religious/personal belief exemptions are not permitted. This bill now requires the California Department of Public Health (CDPH) to develop a standardized form for physicians to complete — under penalty of perjury — for school children to receive medical exemption (ME) from vaccinations. CDPH will review MEs from schools or day care centers with an immunization rate of less than 95% and from physicians who have submitted five or more MEs in a calendar year. CDPH may deny or revoke an inappropriate ME. Also establishes an appeals process. **Becomes effective Jan. 1, 2021**.

Public Reporting

Procurement contracts

▶***AB 962* (Burke, D-Inglewood)** ■ ●

Requires hospitals with operating expenses of at least $50 million — or, if they are part of a system of hospitals, at least $25 million — to submit a report after July 1, 2021, to the Office of Statewide Health Planning and Development (OSHPD) on their minority, women, lesbian, gay, bisexual, transgender, and disabled veteran-owned business enterprise procurement efforts. Requires OSHPD to post the reports on its website, and to convene a hospital diversity commission to advise and provide recommendations on the best methods to increase procurement with diverse suppliers within hospitals.

Telemedicine

Telehealth coverage

▶***AB 744* (Aguiar-Curry, D-Winters)** ■

Requires health plan and insurer policies issued, amended, or renewed on or after Jan. 1, 2021, to cover telehealth services on the same basis and to the same extent as the same service provided in person. Eases Medi-Cal telehealth restrictions.

Women and Children

California Dignity in Pregnancy and Childbirth Act

▶***SB 464* (Mitchell, D-Los Angeles)** ● ●

Requires hospitals — as well as alternative birthing centers and specified primary care clinics — that provide perinatal care to implement an implicit bias program for all employed perinatal care providers. Each perinatal care provider must complete initial basic training and a refresher course every two years. The facility must also offer the training to physicians who treat perinatal patients but are not employed by the facility. This bill also requires hospitals to report on severe maternal morbidity and pregnancy-related deaths.

Index by Bill Author

Index by Bill Author *continued*

Index by Bill Number

Index by Bill Number *continued*

Index by Staff Role

The Impact and Importance of Nursing

World Health Organization

2020 International Year of the Nurse and Midwife

FAMILIES

PATIENTS

COMMUNITIES

Health advice

Reduce mortality

Protection & safety

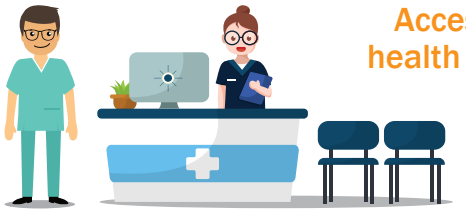
Employed nurses strengthen local economies

Quality of health care

Care Managers & Providers

Psychosocial & holistic care

Public health



Access to health care

Nurses on Boards

Slowing health care costs

Social determinants of health

Scientists

Groceries

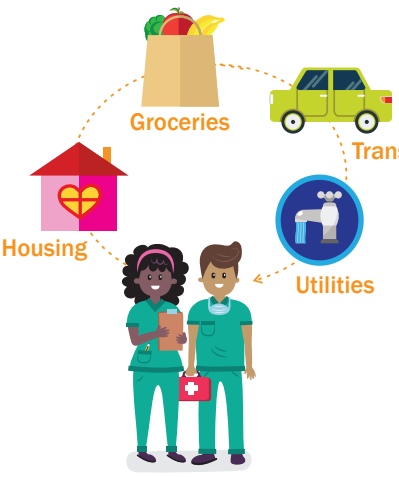
Transport

Housing

Utilities

Innovators

Policy makers



To download a copy of this infographic

HealthImpact
Optimizing health through nursing

ADDRESS: 663 13th Street, Suite 300, Oakland CA 94612
PHONE: (510) 832-8400 **www.healthimpact.org**

See reverse for articles related to each topic above

PSYCHOSOCIAL & HOLISTIC CARE

Nurse-Led Intervention Attempts to Address Posttreatment Needs of Lymphoma Survivors

"She Is an Angel Sent from Heaven," Shawnee Woman Honors Nurse Who Helped in Her Darkest Times.

PROTECTION & SAFETY

Nurse Practitioner Student Creates Screening to Identify Human Trafficking Victims.

CARE MANAGERS & PROVIDERS

What is Nursing?

ACCESS TO HEALTH CARE

Approaches to Improving the Contribution of The Nursing and Midwifery Workforce to Increasing Universal Access to Primary Health Care for Vulnerable Populations.

PUBLIC & COMMUNITY HEALTH

Status of Breastfeeding and Child Immunization Outcomes in Clients of the Nurse–Family Partnership.

NURSES ON BOARDS

Coalition to improve the health of communities and the nation through the service of nurses on boards and other bodies.

POLICY MAKERS

Nurses have a key voice in ongoing efforts to improve public health and influence health policy.

ADVICE ON PERSONAL HEALTH

Effects of Nurse-Led Support Via WeChat, a Smartphone Application, for Breast Cancer Patients After Surgery: A Quasi-Experimental Study.

Colorado Nurses Launching Hotline for Your Marijuana Questions.

SCIENTISTS

The Rise of the Nurse Scientist: Nurse Researchers Take Center Stage.

INNOVATORS

Nurse Invents Medical Device to Help Son's Blood Transfusions.

ECONOMIC STIMULUS

Training Nurses to Help Patients Manage Financial Toxicity.

Hospitals Provide a Pulse in Struggling Rural Towns.

SLOWING HEALTH CARE COSTS

Case Management Programs in Emergency Department to Reduce Frequent User Visits: A Systematic Review.

How Providing Social Supports and Care Coordination May Lower Medical Costs for Seniors Living at Home.

QUALITY

Giving the Gift of Dying on Their Own Terms, Hospice Nurse Helps Patients and Families.

REDUCING MORTALITY

RN Assessments of Excellent Quality of Care and Patient Safety Are Associated with Significantly Lower Odds of 30-Day Inpatient Mortality: A National Cross-Sectional Study of Acute-Care Hospitals.

SOCIAL DETERMINANTS OF HEALTH

'Health Equity Through Action on The Social Determinants of Health': Taking Up the Challenge in Nursing.

Immigrant Nurse Starts Health Literacy Service for Low Income Communities.

Regional Implementation Project

Organization and Planning

Regional Implementation Project

CALIFORNIA

Regions 1-14

HealthImpact
Optimizing health through nursing

Updated July 2019

Description	Old Calculations Project	Core		Region	
	$/yr	$/yr	Justification * 12 mo	$/yr	Justification * 12 mo
CEO	8,506	8,506	Monthly meetings, planning		
CO	8,186	3,683	Monthly meetings, planning, action items	5,730	Collect regional data, analyze trends, report out to Steering Committee monthly
MD	56,250	8,550	Monthly meetings, planning, action items	31,500	Work with 14 regions to achieve goals
MC		4,218	Monthly meetings, planning, action items	15,540	Work with 14 regions to achieve goals, support MD/CO
LAS	894	894	Finance activities	N/A	
LF	2,050	2,050	Creation of materials, communication	N/A	
Office Assistant		660	Coordination and planning	N/A	
Labor subtotal	75,886	28,561		52,770	
Fringe benefits @ 25%	2,945	7,140		13,192	
Personnel subtotal	78,831	35,701		65,962	
Regional Co-Directors	28,000	N/A		33,600	$1200* 2 Co-Chairs * 14 Regions
Office Supplies	1,000	2,050		N/A	
Printing & Copying		530		N/A	
Travel	5,000	1,500		6,500	
Meetings			***External Funding ***		***External Funding ***
Non-personnel Subtotal	34,000	4,080		40,100	
Personnel and Non-personnel Total	112,831	39,781		106,062	
Shared cost 15%	16,925	5,967		15,909	
Grand Total	129,756	45,748		121,971	/14 regions = $8,712/region

CNO ADVISORY COMMITTEE
2020 ROSTER

Officers

Chair
Anna Kiger, RN, DNP, DSc, MBA, NEA-BC
System Chief Nurse Officer
Sutter Health
2200 River Plaza Drive
Sacramento, CA 95833-4134
(916) 286-6843
kigeraj@sutterhealth.org
Assistant: Sandra Zatta
(916) 286-6539
zattas@sutterhealth.org

Members

Margarita Baggett, RN, MSN
Chief Clinical Officer
UC San Diego Health - Hillcrest Medical Center
9300 Campus Point Drive
San Diego, CA 92037
(858) 249-5537
mbaggett@ucsd.edu

Gloria Bancarz, RN, MSN
System Chief Nursing Officer
Adventist Health
ONE Adventist Health Way
Roseville, CA 95661
(916) 406-1161
gloria.bancarz@ah.org

Dale Beatty
Chief Nursing Officer/Vice President, Patient Care Services
Stanford Health Care
300 Pasteur Drive
Palo Alto, CA 94305-2200
(650) 723-5537
DBeatty@stanfordhealthcare.org

Nancy Blake, RN, PhD, NEA-BC, NHDP-BC, FAAN
Chief Nursing Officer
Harbor - UCLA Medical Center
1000 West Carson Street
Torrance, CA 90502-2059
(424) 306-6595
nblake@dhs.lacounty.gov

Jennifer R. Castaldo, RN, MSHA, BSN, NEA-BC
Vice President/Chief Nursing Officer
Henry Mayo Newhall Hospital
23845 McBean Parkway
Valencia, CA 91355-2083
(661) 200-1027
castaldojr@henrymayo.com
Assistant: Kasey Lee

Tim L. Clark, RN, BSN, MBA
Regional Chief Operating Officer/Chief Nursing Officer
Physicians for Healthy Hospitals
1117 East Devonshire Avenue
Hemet, CA 92543-3083
(951) 766-6472
Tim.Clark@phh.ms

Connie Clemmons-Brown
System SVP, Patient Care Services – Professional Practice
Dignity Health - Greater Sacramento
185 Berry Street
San Francisco, CA 94107-1773
Connie.ClemmonsBrown@DignityHealth.org

Annette Greenwood, BSN, MHA, RNC
Senior Vice President/Chief Nursing Officer
Riverside Community Hospital
4445 Magnolia Avenue
Riverside, CA 92501-4199
(951) 788-3430
annette.greenwood@hcahealthcare.com

Karen Grimley, RN, PhD, MBA, FACHE, NEA-BC
Chief Nurse Executive, Assistant Dean UCLA School of Nursing
Ronald Reagan UCLA Medical Center
757 Westwood Plaza
Los Angeles, CA 90095-8358
(310) 267-9304
kgrimley@mednet.ucla.edu

Cheryl Harless, MBA, BSN, RN
Chief Nursing Officer, Northern California Group
Doctors Medical Center of Modesto
1441 Florida Avenue
Modesto, CA 95350-4418
(209) 576-3601
cheryl.harless@tenethealth.com

Beverly Hayden-Pugh, CNO
Senior Vice President/Chief Nursing Officer/Chief Transformation Officer
Valley Children's Healthcare
9300 Valley Childrens Place
Madera, CA 93636-8761
(559) 353-6609
bhayden-pugh@valleychildrens.org

Kelly M. Johnson, PhD, RN, NEA-BC
Vice President, Patient Care Services/Chief Nursing Officer
Lucile Packard Children's Hospital Stanford
725 Welch Road
Palo Alto, CA 94304-1614
(650) 723-4018
kejohnsoncno@stanfordchildrens.org

Linda Knodel, MHA, MSN, NE-BC, CPHQ, FACHE, FAAN
Chief Nurse Executive/Senior Vice President, National Patient Care Services
Kaiser Permanente Oakland Medical Center
One Kaiser Plaza
Oakland, CA 94612
(510) 409-9529
linda.j.knodel@kp.org
Assistant: Dee Sykes
dee.a.sykes@kp.org

Jacalyn A. Liebowitz, BSN, MBA, DNP
Vice President, Chief Nursing Officer, Acute Care Division
Adventist Health
ONE Adventist Health Way
Roseville, CA 95661
(916) 406-1212
LiebowJA@ah.org
Assistant: Donna Collier
(916) 406-1212
colliedl@ah.org

Michelle Lopes, RN, MSN, NEA-BC
System Chief Nursing Executive
John Muir Medical Center - Walnut Creek Campus
1400 Treat Boulevard
Walnut Creek, CA 94597-2142
(925) 947-5343
michelle.lopes@johnmuirhealth.com
Assistant: Roxana Franco
(925) 947-5343
roxana.franco@johnmuirhealth.com

Toby Marsh, RN, MSA, MSN, FACHE, NEA-BC
Chief Nursing/Patient Care Services Officer
UC Davis Medical Center
2315 Stockton Boulevard
Sacramento, CA 95817-2282
(916) 734-2470
tkmarsh@ucdavis.edu

David Marshall, JD, DNP, CENP, FAAN
Senior Vice President/Chief Nursing Executive
Cedars-Sinai Health System
8700 Beverly Blvd.
Los Angeles, CA 90048
(310) 423-2115
david.marshall@cshs.org
Assistant: Lisa Gonzalez
(310) 423-3773
lisa.gonzalez@cshs.org

Theresa Murphy, RN, MS, CENP
Chief Nursing Officer
USC Verdugo Hills Hospital
1812 Verdugo Boulevard
Glendale, CA 91208
(818) 952-4603
theresa.murphy@vhh.usc.edu

Terry Pena, RN, MS-HCA, BSN
Chief Operating Officer/Chief Nursing Officer
San Bernardino Mountains Community Hospital
29101 Hospital Road
Lake Arrowhead, CA 92352
(909) 436-3070
terry.pena@mchcares.com
Assistant: Kristi McCasland
(909) 436-3126
kristi.mccasland@mchcares.com

Connie Rowe, RN, MHA, FACHE, CPHQ
CNO/Vice President, Patient Care Services
Enloe Medical Center - Esplanade Campus
1531 Esplanade
Chico, CA 95926-3386
(530) 332-7369
connie.rowe@enloe.org

Katie Skelton, RN, MBA, NEA-BC
VP Patient Care Services/Chief Nursing Officer
St. Joseph Hospital, Orange
1100 West Stewart Drive
Orange, CA 92868-3891
(714) 771-8270
katie.skelton@stjoe.org
Assistant: Denise Hoon
(714) 744-8898
denise.hoon@stjoe.org

Lauren Spilsbury, RN, MSN
CNO/Vice President, Patient Care Services
Redlands Community Hospital
350 Terracina Boulevard
Redlands, CA 92373-4897
(909) 335-5513
las@redlandshospital.org
Assistant: Theresa Schnetz
(909) 335-5512
tds@redlandshospital.org

Sylvain Trepanier, RN, DNP, CENP, FAAN
Chief Clinical Executive
Providence St. Joseph Health Southern California
3345 Michelson Drive
Irvine, CA 92612
(310) 793-8076
Sylvain.trepanier@providence.org
Assistant: Allison Golden
allison.golden@stjoe.org

Pam Wells, RN, MSN, MSA, NEA-BC
Chief Nursing Officer and Vice President, Patient Care Services
Sharp Memorial Hospital
7901 Frost Street
San Diego, CA 92123-2701
(858) 939-3523
pam.wells@sharp.com

Advisory/Ex-Officio

Mary Bittner, RN, DNP, MPA, CENP
Adjunct Faculty, School of Nursing and Health Professions (SONHP)
University of San Francisco
2130 Fulton St.
San Francisco, CA 94117
bittnermary2@gmail.com

Stephen J. Cavanagh, PhD, MPA, RN, FACHE, FAAN
Dean
Betty Irene Moore School of Nursing, UC Davis
2570 48th St.
Sacramento, CA 95817
(916) 734-4745
sjcavanagh@ucdavis.edu
Assistant: Liz deVictoria
ecdevictoria@ucdavis.edu

Garrett Chan, PhD, RN, APRN, FAEN, FPCN, FNAP, FAAN
Chief Executive Officer
HealthImpact
663 13th Street
Oakland, CA 94612
(510) 832-8400
garrett@healthimpact.org
Assistant: Laura Ford
laura@healthimpact.org

Pilar De La Cruz-Reyes, RN, MSN
Vice President
Health Education Alliance
3866 N. Academy Ave.
Sanger, CA 93657
pdelacruz@mail.fresnostate.edu

Anita Girard, RN, DNP, CNL, CPHQ, NEA-BC
President
American Nurses Association/California
1121 L Street
Sacramento, CA 95814
(408) 396-0162
vicepresident@anacalifornia.org

Marketa Houskova, RN, MAIA, BA
Executive Director
American Nurses Association/California
1121 L Street, Suite 406
Sacramento, CA 95814
(916) 346-4590
marketa@anacalifornia.org
Assistant: Teresa Manquera
(916) 346-4590
anac@anacalifornia.org

Kimberly C. Long, DHA, MSN, FNP

Association of California Nurse Leaders

Joseph Morris, PhD, MSN, RN
Executive Officer
California Board of Registered Nursing
1747 N. Market Boulevard
Sacramento, CA 95834-1924
(916) 574-7603
joseph.morris@dca.ca.gov
Assistant: Brazil Smith
(916) 574-7601
brazil.smith@dca.ca.gov

Kimberly Tomasi, RN, MSN
Chief Executive Officer
Association of California Nurse Leaders
180 Promenade Circle
Sacramento, CA 95834
(916) 779-6949
kim@acnl.org
Assistant: Wendy Smolich
wendy@acnl.org

Staff

BJ Bartleson, RN, MS, NEA-BC
Vice President Nursing & Clinical Services
California Hospital Association
1215 K St.
Sacramento, CA 95814
(916) 552-7537
bjbartleson@calhospital.org

Gail Blanchard-Saiger
Vice President, Labor and Employment
California Hospital Association
1215 K St.
Sacramento, CA 95814
(916) 552-7620
gblanchard@calhospital.org
Assistant: Michele Coughlin
(916) 552-7672
mcoughlin@calhospital.org

Teri Hollingsworth
Vice President, Human Resource and Education Services
Hospital Association of Southern California
515 South Figueroa Street
Los Angeles, CA 90071-3300
(213) 538-0763
thollingsworth@hasc.org

Barb Roth
Administrative Assistant
California Hospital Association
1215 K Street, Suite 800
Sacramento, CA 95814
(916) 552-7616
broth@calhospital.org

CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

GUIDELINES FOR THE
CALIFORNIA HOSPITAL ASSOCIATION
CNO ADVISORY COMMITTEE

I. NAME

The name of this committee shall be the CNO Advisory Committee

II. MISSION

The mission of the CNO Advisory Committee is to advise CHA on key policy and advocacy issues specific to hospital and health system nurse executive practice.

III. PURPOSE

The purpose of the CNO Advisory Committee is to provide support for member hospitals and to solicit input for CHA advocacy on key issues.

The committee will provide a forum to:

1. Provide advice and expert analysis on issues of importance.
2. Cooperate with CHA on programs and activities and to support the positions and services of CHA.
3. Make recommendations related to state and federal legislation and regulations related to hospital and health system nursing and clinical services.
4. Conduct other activities approved by the CHA Board of Trustees.

IV. COMMITTEE

The Committee (the "Committee") shall consist of no more than 25 voting members representative of the types, location, and size of CHA institutional members.

A. MEMBERSHIP

1. Membership on the Committee shall be based upon institutional membership in CHA.
2. Committee members shall consist of various representatives from large hospital systems, public institutions, private facilities, free-standing facilities, small and rural facilities, university/teaching facilities and specialty facilities.
3. Non-hospital members will be considered ex-officio members including faculty, consumers and other members of the health professions who are beneficiaries of nursing practice and can only be appointed to the committee at the discretion of the CHA staff.
4. Committee members are appointed by CHA staff.
5. Committee members shall serve three-year terms staggered in a fair and equitable manner as determined by the nominating committee and accepted by the Committee.

Members are limited to two consecutive terms. There must be at least a one-year interval before being eligible for another term.

B. MEMBER RESPONSIBILITIES

1. Accept their appointment with an interest and willingness to serve.
2. Mark their calendars with the advance notice of meetings for the year and make every reasonable effort to keep those dates and times open for the meeting.
3. Attend every meeting possible.
4. Be prepared by reviewing any discussion material provided in advance of the meeting.
5. Contribute to the discussion and consider the subject matter for the benefit of the association as a whole, not just an individual member.
6. Respond to requests for input and feedback on business and issues before the Committee.
7. Disseminate information to committees and to member organizations as appropriate.

C. COMMITTEE MEETINGS

1. Meetings of the Committee shall be held quarterly in person. Additional conference call or web-based meetings may be scheduled as indicated.
2. To maintain continuity substitution of members is not normally allowed.
3. Three consecutive unexcused absences by a Committee member will initiate a review by the Chair and CHA staff for determination of the Committee member's continued service on the Committee.
4. Special meetings may be scheduled by the Chair, majority vote or CHA staff.

D. VOTING

1. Voting rights shall be limited to members of the Committee, and each member present shall have one vote. Voting by proxy is not acceptable.
2. All matters requiring a vote of the Committee must be passed by a majority of a quorum of the Committee members present at a duly called meeting or telephone conference call.

E. QUORUM

Except as set forth herein, a quorum shall consist of a majority of members present/participating or not less than eight.

F. MINUTES

Minutes of the Committee shall be recorded at each meeting, disseminated to the membership, and approved as disseminated or as corrected at the next meeting of the Committee.

V. OFFICERS

The officers of the Committee shall be the Committee Chair, Vice Chair, Immediate Past Chair and CHA staff.

The Chair shall be appointed by CHA staff for a two-year term. Should a Chair vacate his/her position prior to the end of the term, CHA staff will appoint a replacement to complete the remainder of the term.

The responsibilities of the Committee Chair are to:

1. Monitor staff in the execution of their responsibilities to the Committee.
2. Conduct meetings which assure an orderly flow of the discussion and a constructive use of the group's time.
3. Interpret the action of the Committee and speak for the Committee when necessary to report to the CHA Board of Trustees.

The responsibilities of the Committee Vice Chair are to:

1. Assist the Chair in the execution of his/her responsibilities to the Committee.
2. In the absence of the Chair, assume the role and responsibilities of the Chair.

VI. GENERAL PROVISIONS

A. COMMITTEE ACTIVITIES
Committee activities, including goals and objectives, shall be developed by the Committee with approval by CHA staff. Quarterly updates and progress reports shall be completed by the Committee and CHA staff. Committee staff should communicate regularly with the Committee on the activities and priorities of the Committee. The Committee may request that staff develop a general work plan which defines the goals and objectives of the Committee for the coming year.

B. SUB-COMMITTEES
Task forces or subcommittees of the Committee may be formed at the discretion of the Committee Chair and member and CHA staff for the purpose of con ducting activities specific to a special topic or goal.

C. STAFF SUPPORT
Staff leadership shall be provided by CHA with Regional Association staff leadership provided by Hospital Council, the Hospital Association of Southern California, and the Hospital Association of San Diego and Imperial Counties. The primary office and public policy development and advocacy staff of the Committee shall be located within the CHA office.

VII. AMENDMENTS

These Guidelines may be amended by a majority vote of the members of the Committee at any regular meeting of the Committee and with approval by CHA.

VIII. LEGAL LIMITATIONS

Any portion of these Guidelines which may be in conflict with any state or federal statutes or regulations shall be declared null and void as of the date of such determination.

Any portion of these Guidelines which are in conflict with the Bylaws and policies of CHA shall be considered null and void as of the date of the determination.

Information provided in meetings is not to be sold or misused.

IX. CONFIDENTIALITY FOR MEMBERS

Many items discussed are confidential in nature, and confidentiality must be maintained. All Committee communications are considered privileged and confidential, except as noted.

X. CONFLICT OF INTEREST

Any member of the Committee who shall address the Committee in other than a volunteer relationship excluding CHA staff and who shall engage with the Committee in a business activity of any nature, as a result of which such party shall profit either directly or indirectly, shall fully disclose any such financial benefit expected to CHA staff for approval prior to contracting with the Committee and shall further refrain, if a member of the Committee, from any vote in which such issue is involved.

CNO ADVISORY COMMITTEE
MEETING MINUTES
November 6, 2019 / 10 a.m. – 12 p.m.

Members Present: **Margarita Baggett, Dale Beatty, Nancy Blake, Mary Bittner, Garrett Chan, Tim Clark, Karen Grimley, Cheryl Harless, Marketa Houskova, Anna Kiger, Toby Marsh, Theresa Murphy, Terry Pena, Connie Rowe (Donna Larson), Katie Skelton, Kimberly Tomasi, Pam Wells**

Staff: **BJ Bartleson, Gail Blanchard-Saiger, Teri Hollingsworth, Barb Roth, Judith Yates**

I. CALL TO ORDER/INTRODUCTIONS

Ms. Kiger called the committee meeting to order at 10:00 a.m.

III. OLD BUSINESS

A. SB 227 (Leyva) Nurse Staff Ratio Bill (Bartleson)

CHA was able to get two words" unpredictable and uncontrollable", added to SB 227). Sutter Health System uses "Clairvia", a comprehensive software suite of staffing and scheduling tools that includes an acuity system, staff management, and documentation systems to accurately staff and record minute to minute changes in patient and staffing activity. EPIC has a workload module as well. Nursing Solutions Inc. produces information on nursing turnover (request to have the information to BJ for committee dissemination).

- *ACTION: Committee to send information regarding Nursing Solutions Inc. to Ms. Bartleson*
- *ACTION: CHA is seeking best practices to share.*

B. HealthImpact Regional Summit Initiative Update (Bartleson/Chan)

HealthImpact work group has identified 14 different regions in California and 6 priorities for the future of nursing in California. This work will lead to improved student placement capacity across the state.

- *ACTION: HealthImpact is seeking funding assistance to manage the consortia and implement best practices across the state. They are also looking for any feedback CNO's can provide.*

VII. NEW BUSINESS

A. Licensing, Certification and Regulatory Update (Bartleson)

Information provided in meeting packet.

- *ACTION: Information only.*

B. AB 5, SB 464, & Other Legislative Information (Bartleson/Blanchard-Saiger)

AB 5 -Based upon the present interpretation of AB 5, it is now risky to use certain classifications of employees as contract employees. Hospitals should review and re-evaluate any employee or business to business employee contracts. In particular, CNOs should review contracts with staffing agencies and their indemnification provisions.

SB 464 -Hospitals will need to provide training to perinatal staff and must offer implicit bias training to physicians, but the bill does not require physicians to take the implicit bias training.

- *ACTION: Information only.*

C. Workplace Violence (Hollingsworth/Murphy)

Quality and Safety opportunities also includes workplace safety. Therefore, the roles and expectations of law enforcement in hospital settings should be evaluated and updated. A video was shared with the committee, at which time it was noted that the terminology used by medical personnel and law enforcement is not consistent. A suggestion was made to coordinate an ED collaborative to further assess and discuss next steps. Rural hospitals have different concerns with regards to law enforcement involvement and need consideration on their unique aspects.

- *ACTION: Committee Members: please send input and resources to CHA (Bartleson and Blanchard-Saiger)*
- *ACTION: Ms. Bartleson, Ms. Hollingsworth, Ms. Blanchard-Saiger and Ms. Wheeler to discuss further and report back to the committee.*

D. PSPS – Public Safety Power Shutoff (Bartleson)

Summary provided in meeting packet.

- *ACTION: Information only.*

E. FDA Statement on Concerns with Medical Device Availability Due to Certain Sterilization Facility Closures

Manufacturing companies, primarily in GA and IL, are being fined, and closed, by their states for using ethylene oxide in the sterilization process. This poses a potential for supply deficits in hospital for multiple items used throughout the hospital.

- *ACTION: Committee Members: Please check in with material management departments and advise CHA if you hear/see anything regarding this shortage.*

X. INFORMATION

A. Disaster Preparedness: Mitigation, Response, and Recovery to Ensure Staffing Excellence in Los Angeles County
B. CNO Advisory Committee Roster
C. CNO Advisory Committee Guidelines
D. July 10, 2019 Meeting Minutes – **deemed approved by email.**

VIII. NEXT MEETING

To be advised.

IX. ADJOURNMENT

Having no further business, the committee adjourned at 12:02 p.m.