MINUTES OF THE GROSSMONT HEALTHCARE DISTRICT BOARD OF DIRECTORS
Special Meeting
August 15, 2017

The Board of Directors of Grossmont Healthcare District (District) held a special joint meeting with the Board of Directors of Grossmont Hospital Corporation (GHC) on Tuesday, August 15, 2017, at 12:00 p.m. in the Main Auditorium of Sharp Grossmont Hospital, 5555 Grossmont Center Drive, La Mesa, California.

District Directors Present: Robert Ayres, Gloria Chadwick, Michael Emerson, Virginia Hall, Randy Lenac

District Directors Absent: None

District Staff Present: Barry Jantz, Chief Executive Officer
Tom Saiz, Chief Financial Officer
Jeff Scott, General Counsel (arrived 1:00 p.m.)
Erica Salcuni, Communications Specialist
Rick Griffin, Public Relations Consultant

A. CALL TO ORDER

President Emerson welcomed the respective board members and staff members of both the District and GHC and called the meeting to order at 12:13 p.m.

B. PLEDGE of ALLEGIANCE:

President Emerson led in the pledge of allegiance.

C. APPROVAL OF AGENDA:

It was moved by Director Chadwick, seconded by Director Ayres, and unanimously carried (5-0) to adopt the agenda.

D. PUBLIC COMMENT

There was no public comment.

E. GROSSMONT HEALTHCARE DISTRICT PRESENTATIONS

Presentations from Community Partners – President Michael Emerson introduced the following individuals from the County of San Diego to make presentations and answer questions from the board members.

- Report on Public Health Services – Leslie Ray, Senior Epidemiologist – County of San Diego Public Health Services

- Seniors In Crisis Pilot Program – Chuck Matthews, Interim Director, Aging and Independence Services, County of San Diego Health and Human Services Agency

The detailed presentations provided are included as links from the August 15, 2017, agenda on the District's website.

F. ANNUAL REPORT FROM SHARP GROSSMONT HOSPITAL

Sharp Grossmont Hospital CEO Scott Evans introduced his staff members to make the following presentations and answer questions from the board members.

- Strategic Plan – Jason Broad, Vice President

- State of the Facilities/Master Plan Update – Anthony D'Amico, Chief Operating Officer

- Nursing Report/Patient Initiatives – Louise White, Chief Nursing Officer

- Year-To-Date Financial Report – Daniel Kindron, Chief Financial Officer

- Annual Quality and Safety Report – Nancy Greengold, Chief Medical Officer

The detailed presentations provided are included as links from the August 15, 2017, agenda on the District's website.

G. OPEN DISCUSSION

Aside from the general questions and discussion taking place during the presentations listed above, there was no additional open discussion.

President Emerson and CEO Evans thanked the presenters and staff members for the hard work and preparation that went into today's reports.

H. ADJOURNMENT:

There being no further business, on a motion duly made, seconded, and unanimously carried, the Board adjourned at 2:25 p.m.

Respectfully submitted,

Virginia Hall

Virginia Hall, RN, Secretary

ATTEST:

Michael Emerson, RDO, President

SHARP Grossmont Hospital

Joint Meeting of the Boards

Grossmont Healthcare District
Grossmont Hospital Corporation

August 15, 2017

Call to Order
GHD President Michael Emmerson

Approval of Agenda

Public Comment

Opportunity for citizens to speak on items of interest within subject matter jurisdiction of the District. For the record, please state your name. “Request to speak”: cards should be filled out in advance and presented to the Board President or the recording secretary. The Board has a policy limiting any speaker to no more than five minutes.

Grossmont Healthcare District Report

EXPLORING EAST REGION TRENDS AND STATISTICS

Presented by Leslie Upledger Ray, Senior Epidemiologist

Presented to Grossmont Healthcare District

County of San Diego, Health & Human Services Agency, Public Health Services, Community Health Statistics Unit

August 15th, 2017

LIVE WELL SAN DIEGO

COUNTY OF SAN DIEGO VISION

LIVE WELL SAN DIEGO

Building Better Health

Living Safely

Thriving

COLLECTIVE IMPACT

BUILDING BETTER HEALTH

Did you know…

Change your life by…

- **Walking for 30 minutes every day**
- **Eating healthy, at least 5 fruits and veggies daily**
- **Not smoking!**

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

LIVE WELL SAN DIEGO
LIVEWELLSD.ORG

3 BEHAVIORS, 2013-2015

	East Region	San Diego County
Smoking	**Over 1 out of 8** teens and adults were current smokers.	**1 out of every 9** teens and adults were current smokers.
Lack of Physical Activity	**20.7%*** of children engaged in physical activity for at least one hour daily.	**23.2%** of children engaged in physical activity for at least one hour daily.
Diet	**Over 1 out of 4** residents ate fast food three or more times in the past week.	**1 out of 5** residents ate fast food three or more times in the past week.

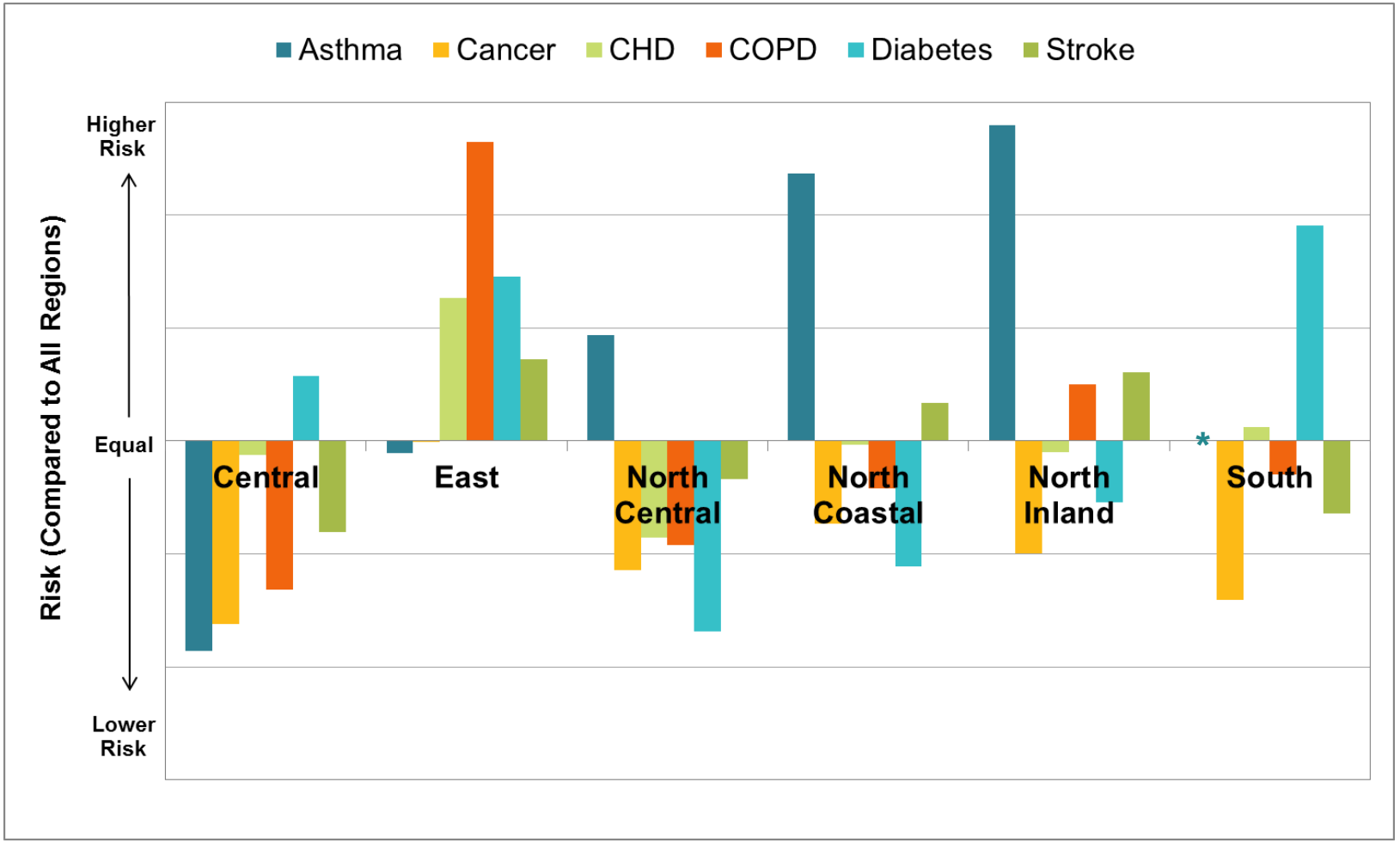
*Indicates a statistically unstable estimate. Proceed with caution. Estimate is included for trending purposes.
Source: UCLA Center for Health Policy Research, California Health Interview Survey (CHIS), 2013-2015.

4 DISEASES, 2013-2015

	East Region	San Diego County
Cancer	Cancer was the leading cause of death.	Cancer was the leading cause of death.
Heart Disease & Stroke	**8.6%** adults had ever been diagnosed with heart disease.	**6.8%** of adults had ever been diagnosed with heart disease.
Diabetes	**Over 1 out of 11** adults had ever been diagnosed with diabetes.	**1 out of 12** adults had ever been diagnosed with diabetes.
Lung Disease	**Over 1 out of 6** residents had ever been diagnosed with asthma.	**1 out of 7** residents had ever been diagnosed with asthma.

*Indicates a statistically unstable estimate. Proceed with caution. Estimate is included for trending purposes.
Source: UCLA Center for Health Policy Research, California Health Interview Survey (CHIS), 2013-2015.

Risk of 3-4-50† Outcomes Compared to San Diego County by Region, 2015



Note: 2014 and 2015 Preliminary Data

* Risk was not calculated for fewer than 5 events.

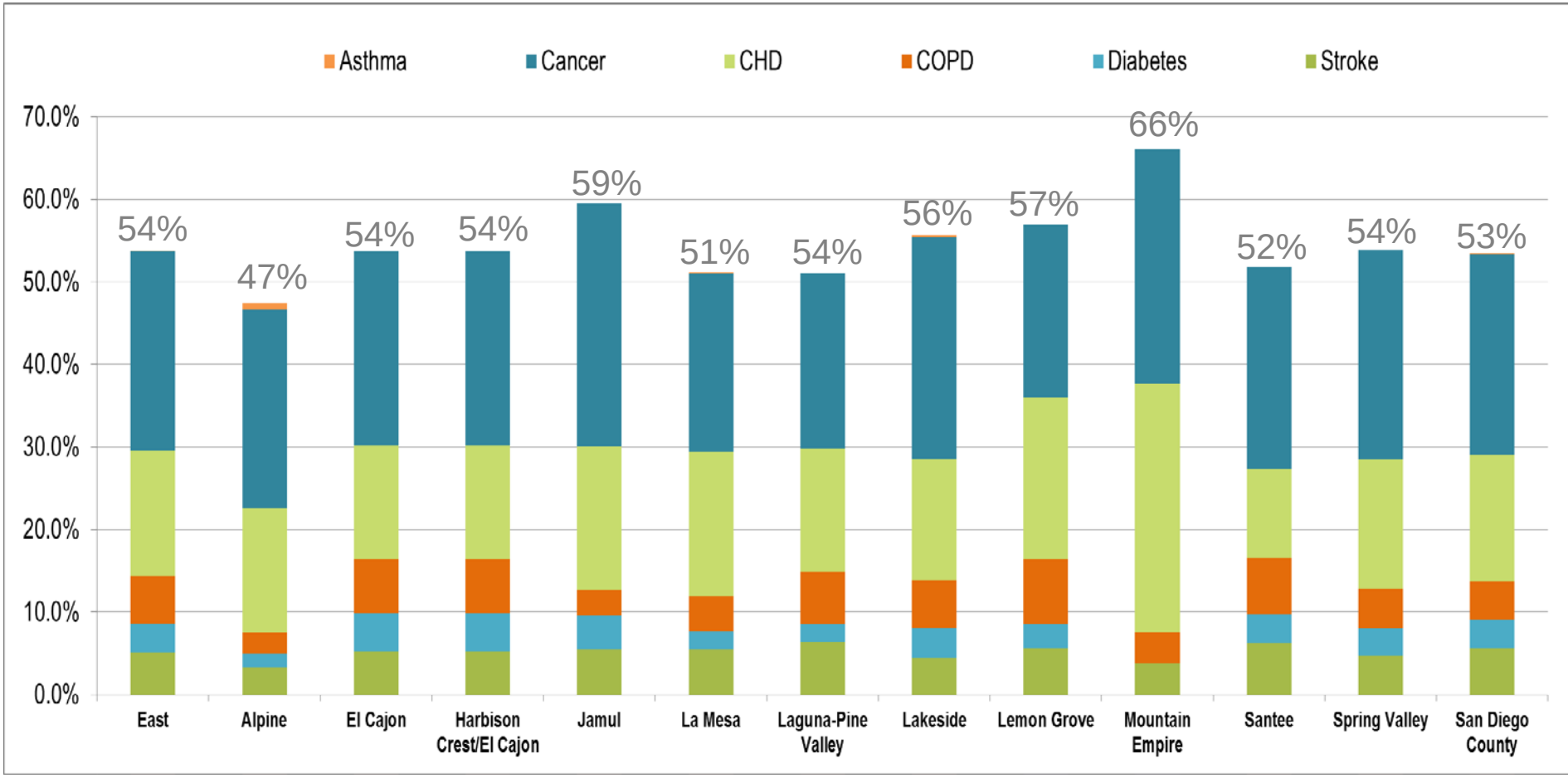
†3-4-50 deaths include stroke, coronary heart disease (CHD), diabetes, COPD, asthma, and cancer.

*3-4-50 deaths as a percentage of all cause deaths. Rates per 100,000 population.

Source: California Department of Public Health, 2000-2013 Death Statistical Master Files, 2014-2015 California Vital Records Business Intelligence System (VRBIS), SANDAG, Current Population Estimates, Received 03/2017.

Prepared by: County of San Diego, Health & Human Services Agency, Public Health Services, Community Health Statistics Unit, 2017.

Percentages* of 3-4-50 Deaths in San Diego County by Region, 2015



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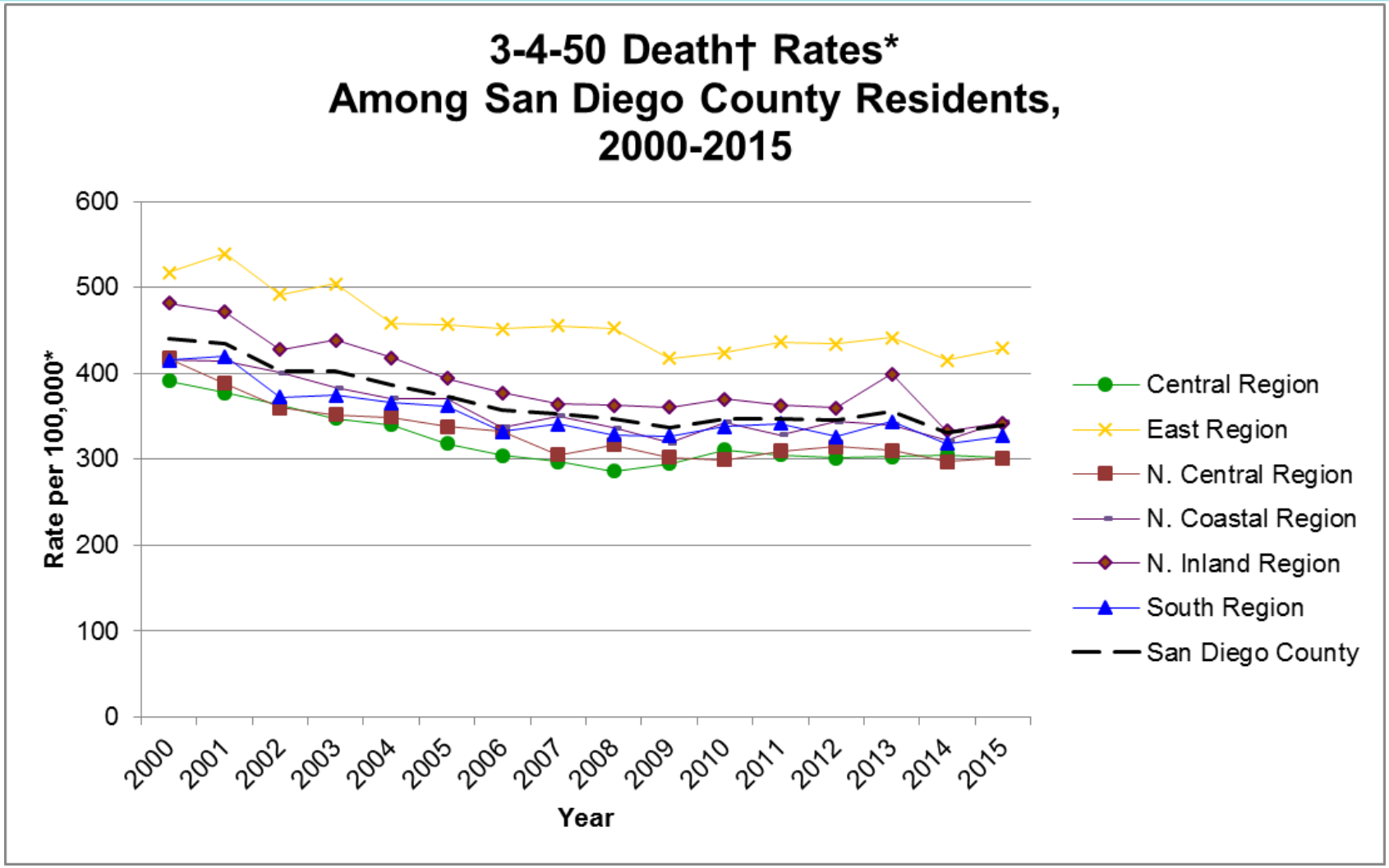
Prepared by: County of San Diego, Health & Human Services Agency, Public Health Services, Community Health Statistics Unit, 2017.

3-4-50 CHRONIC DISEASE DEATH RATES, TREND 2000-2015



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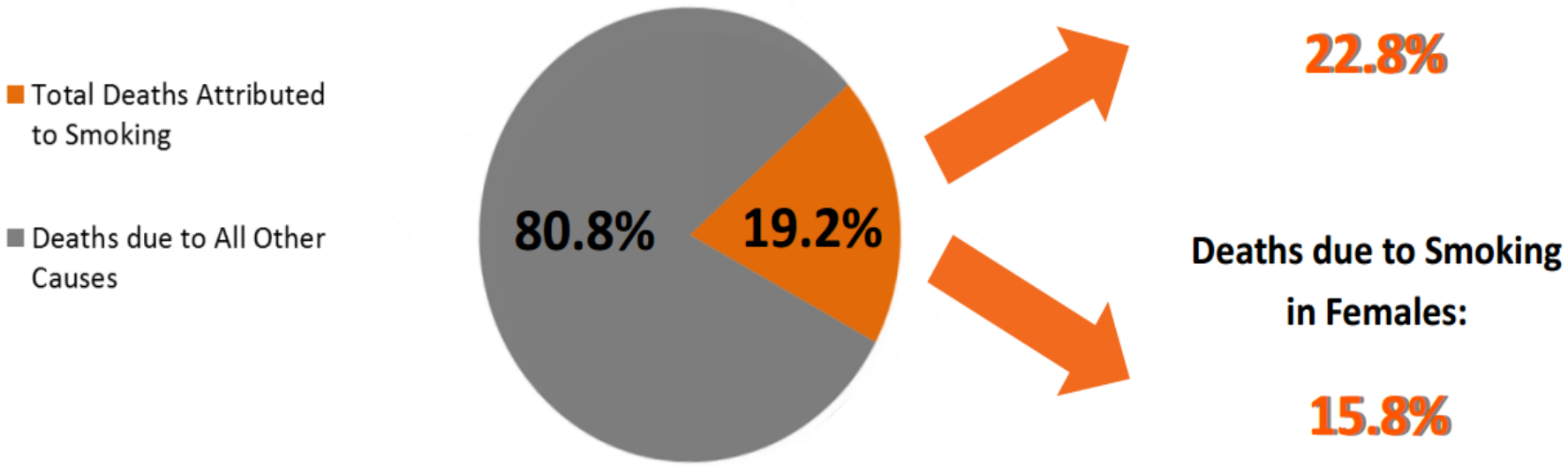
Prepared by: County of San Diego, Health & Human Services Agency, Public Health Services, Community Health Statistics Unit, 2017.

2015 Deaths and Estimates of Smoking-Attributable Mortality (SAM) for East Region Adults 35 Years of Age and Older

2015 Smoking-Attributable Mortality (SAM) for East Region Adults 35 Years of Age and Older, Total and by Gender

	Total Population 35+	Males 35+	Females 35+
Total Population 35 and Over	253,662	121,469	132,193
Total Number of Deaths	3,700	1,796	1,904
Total Deaths Attributed to Smoking	711	410	301
Percent Deaths Attributed to Smoking	**19.2%**	**22.8%**	**15.8%**

2015 Deaths Due to Smoking, Total Population 35+

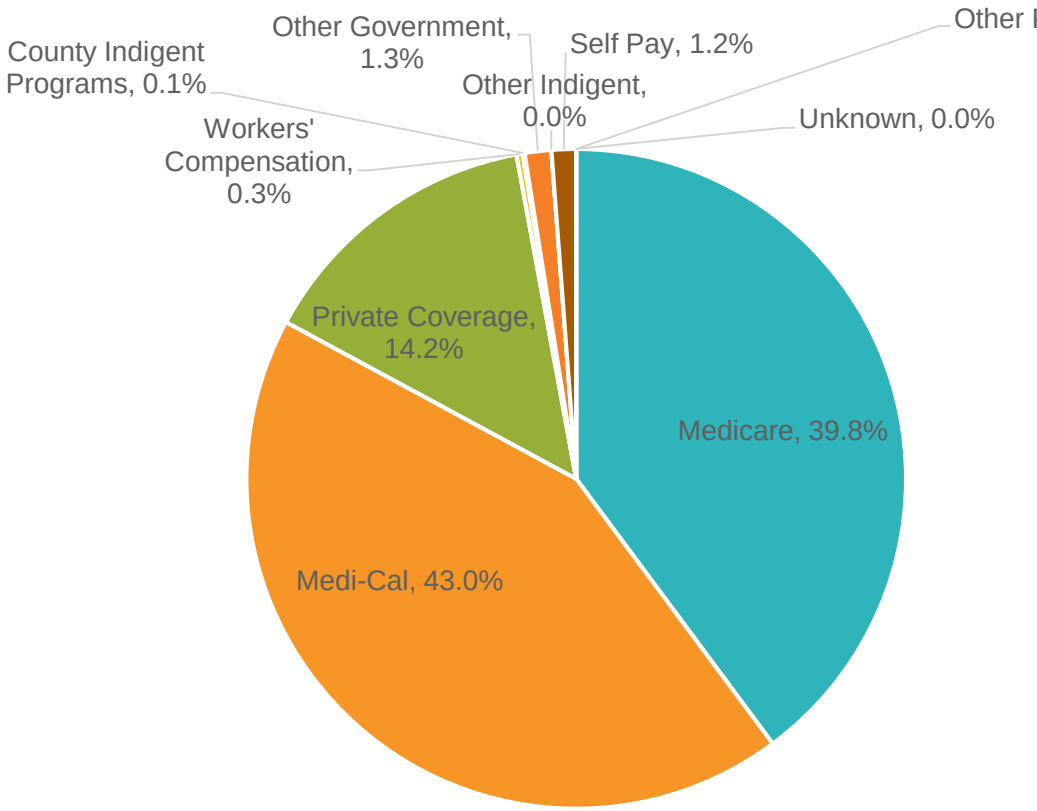


SHARP GROSSMONT HOSPITAL

3 out of every 4 Grossmont Hospital clients are residents of East Region in 2015.

Rank	Principal Diagnosis Group, 2016	#	%
1	Circulatory System	4,057	13.1%
2	Pregnancies	3,966	12.8%
3	Births	3,734	12.1%
4	Digestive System	2,892	9.3%
5	Respiratory Sysytem	2,309	7.5%
6	Infections	2,097	6.8%
7	Injuries/Poisonings	1,927	6.2%
8	Mental Disorders	1,907	6.2%
9	Musculoskeletal System	1,643	5.3%
10	Genitourinary System	1,356	4.4%

Sharp Grossmont Hospital by Payer Source, 2016

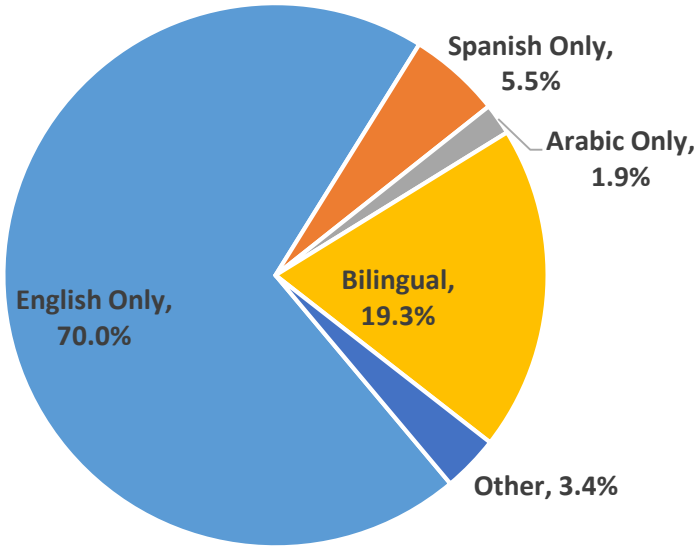


Source: Office of Statewide Health Planning and Development (OSHPD), 2016 Hospital Discharge Summary Report.

EAST REGION DEMOGRAPHICS

- 13% of East Region residents had no health insurance in 2015.
  - Residents ages 18-24 and 25-44 were least likely to be insured.
- East Region had a slightly higher median household income than the county ($65,137 and $64,309, respectively).
- Primarily white (57%) and Hispanic (28%) residents.
- In 2015, nearly 1.9% East Region residents 5+ years spoke Arabic only at home.
  - There were 8,400 Arabic only speakers in East Region.

Language Spoken at Home in East Region, Population Ages 5+, 2015



Source: U.S. Census Bureau, 2011-2015 American Community Survey 5-Year Estimates.

MAJOR EAST REGION HEALTH TRENDS

- **Chronic disease** is the leading cause of death among East Region residents.
  - Cancer is the number one cause of death, followed by CHD. However, East Region residents are at the highest risk of death due to COPD.
- Chlamydia and Pneumonia are the leading communicable diseases in East Region.
  - Compared to the county, East Region had higher rates of flu hospitalization and pneumonia medical encounters.
- Unintentional injuries (all causes), including the burden of fall-related injuries and motor vehicle injuries are the leading types of injuries in East Region.
- With the population of those 65 years and older projected to have the largest increase by 2030, Alzheimer's Disease and Other Dementias (ADOD) is one of the leading health concerns in East Region.
  - By 2030, there will be an estimated **21,500** East Region residents 55 years and older, living with ADOD; accounting for **nearly a quarter** of the entire population in the county.
- About 15% of live births were to East Region mothers.
  - Infant mortality and emergency department discharges due to maternal complications are the major maternal and child health concerns in East Region. Rates are higher than in the county overall.

Source: Community Health Statistics Unit, Community Health Profiles, 2013.

FOR MORE INFORMATION

For more information, including data, resources and reports, from Public Health Services:

www.SDHealthStatistics.com

Leslie.Ray@sdcounty.ca.gov

QUESTIONS?


PublicHealth
LiveWellSanDiego
MaternalHealth
Alzeimer'sDisease
CommunityHealth
WellBeing
Wellness
Hospitalization
Economic
ChildHealth
Poverty
CommunicableDisease
Environment
Demographics
Death
FamilyStructure
Gender
Income
Economy
SubstanceAbuse
Exercise
MentalHealth
Employment
Violence
CommunityHealthStatistics
BehavioralHealth
Injury
Age
SubstanceUse
Seniors
Chronic
LiveWell
Education
PopulationHealth
Community
Dementias
Behavioral
ChronicDisease
Health
Disease
LinguisticIsolation
SocioeconomicStatus
HealthOutcomes
MiddleAged
Race/Ethnicity
EmergencyDepartment
Language
StandardofLiving

SENIORS IN CRISIS

Chuck Matthews, PhD, MBA

Interim Director, Aging and Independence Services
County of San Diego Health and Human Services Agency

LIVE WELL SAN DIEGO

HELPING SENIORS AND FAMILIES OVERWHELMED BY ALZHEIMER'S

LIVE WELL SAN DIEGO

- Chairwoman Dianne Jacob's 2017 State of the County
- San Diegans 65+ are the fastest-growing age group
- 64,000+ San Diegans have Alzheimer's disease or related dementia (ADRD)
- ADRD individuals too often end up in the ER or jail when needed services and programs may be the best option
- Behavioral symptoms, such as agitation, aggression, medication refusal, and wandering present challenges to caregivers and the system

SYSTEM IMPACT

- San Diegans with ADRD:
  - Are seen by local hospitals roughly 32,000 times a year
  - Are admitted to the hospital twice as often as people the same age without ADRD
  - ADRD hospital readmission = $52,412
  - Non-ADRD hospital readmission = $13,000
- Approximately 25% of hospitalized geriatric patients have delirium and agitation
- Geriatric ED patients are 400% more likely to require social services
- Need to identify/collect data in justice system

THE VISION

- Develop a dementia crisis response model
- Expand and enhance senior response teams
- Recommendations to support law enforcement and criminal justice system response

THE PILOT

- East County
- Within Grossmont Healthcare District
- Stakeholders

SHARP Grossmont Hospital

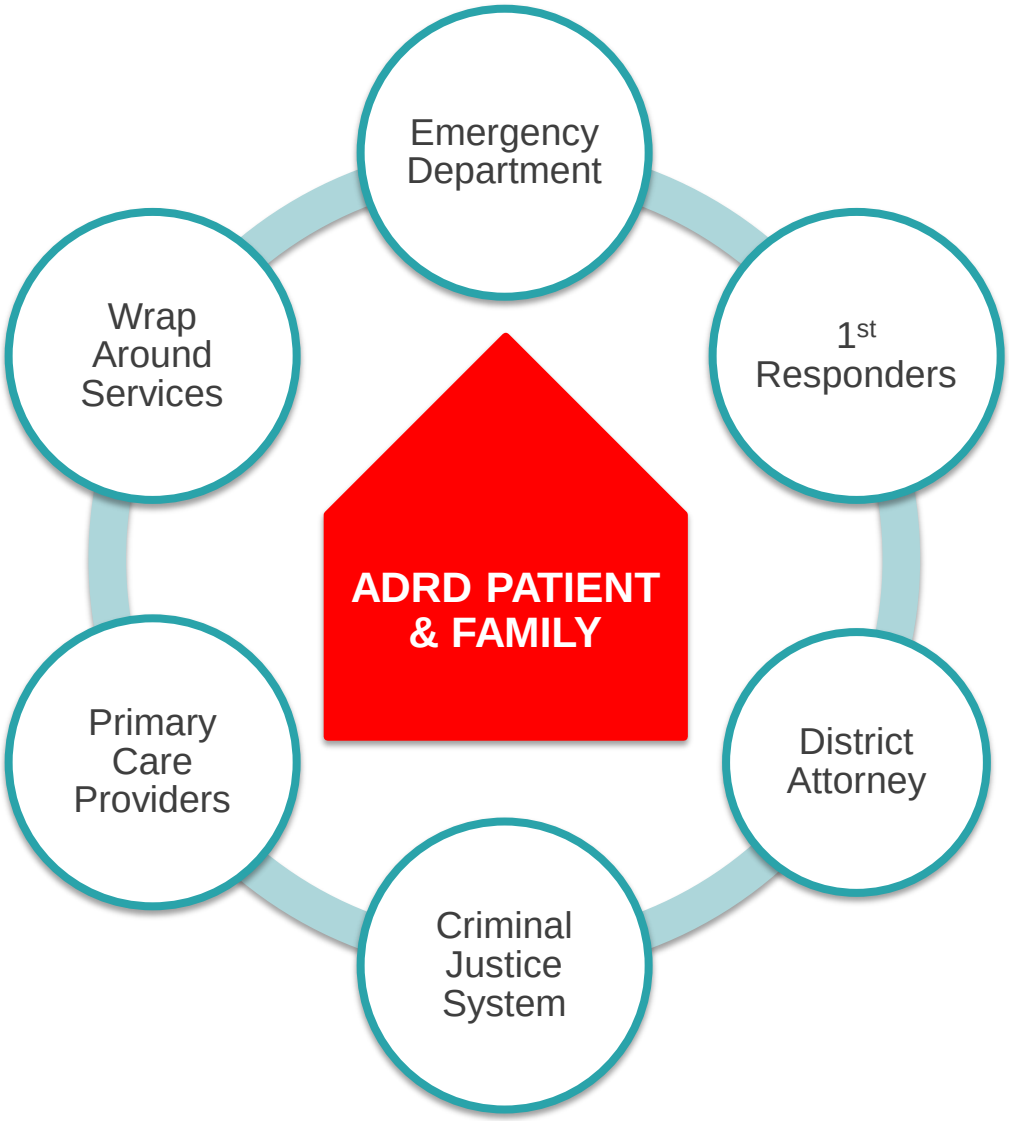
Grossmont Healthcare District

Alzheimer's SAN DIEGO

LIVE WELL SAN DIEGO

LIVEWELLSD.ORG

STAKEHOLDER CONSENSUS



THE MODEL

LIVE WELL SAN DIEGO

Step 1
1st Contact

Community Agency

Emergency Department

First Responders

Step 2
Assess Need

Rapid Response Team (RRT)

Step 3
Meet Client

RRT meets the client at the scene

Step 4
Stabilization

Step 5
Prevention of future events

THE MODEL

Step 4
Stabilization

RRT provides crisis intervention

Step 5
Prevention of future events

Transitional Response Team provides follow-up prior to discharge/release

THANK YOU

Annual Report from Sharp Grossmont Hospital

Scott Evans

Chief Executive Officer

SHARP

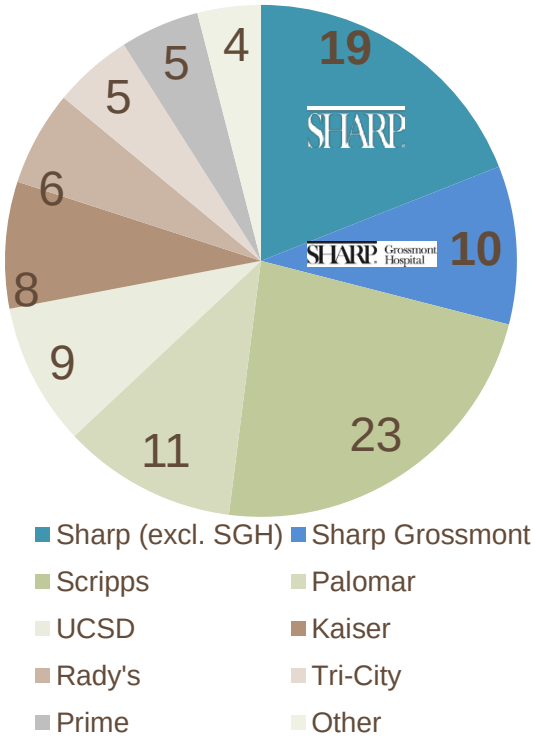
Market Assessment

Jason Broad
Vice President, Facilities & Support Services

Market Share Growth

Sharp HealthCare is the only San Diego health care system to have 16 consecutive years of market share growth

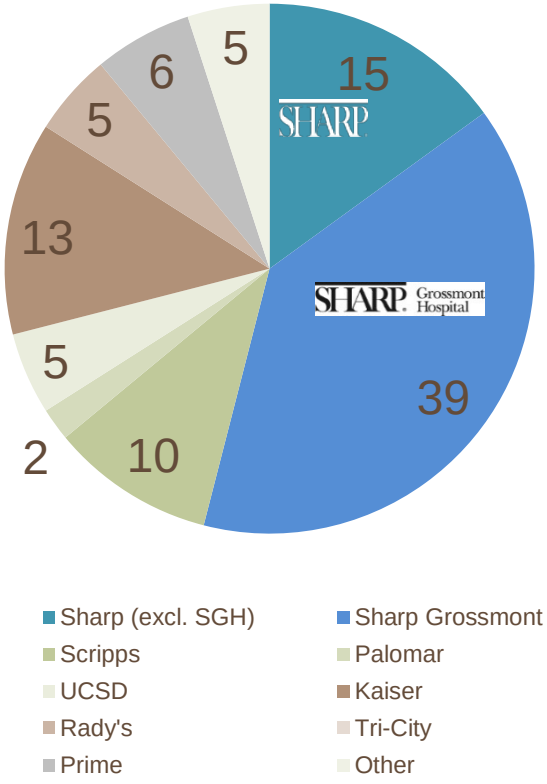
San Diego County
2015 Inpatient Market Share



29%

SHARP

East County
2015 Inpatient Market Share



54%

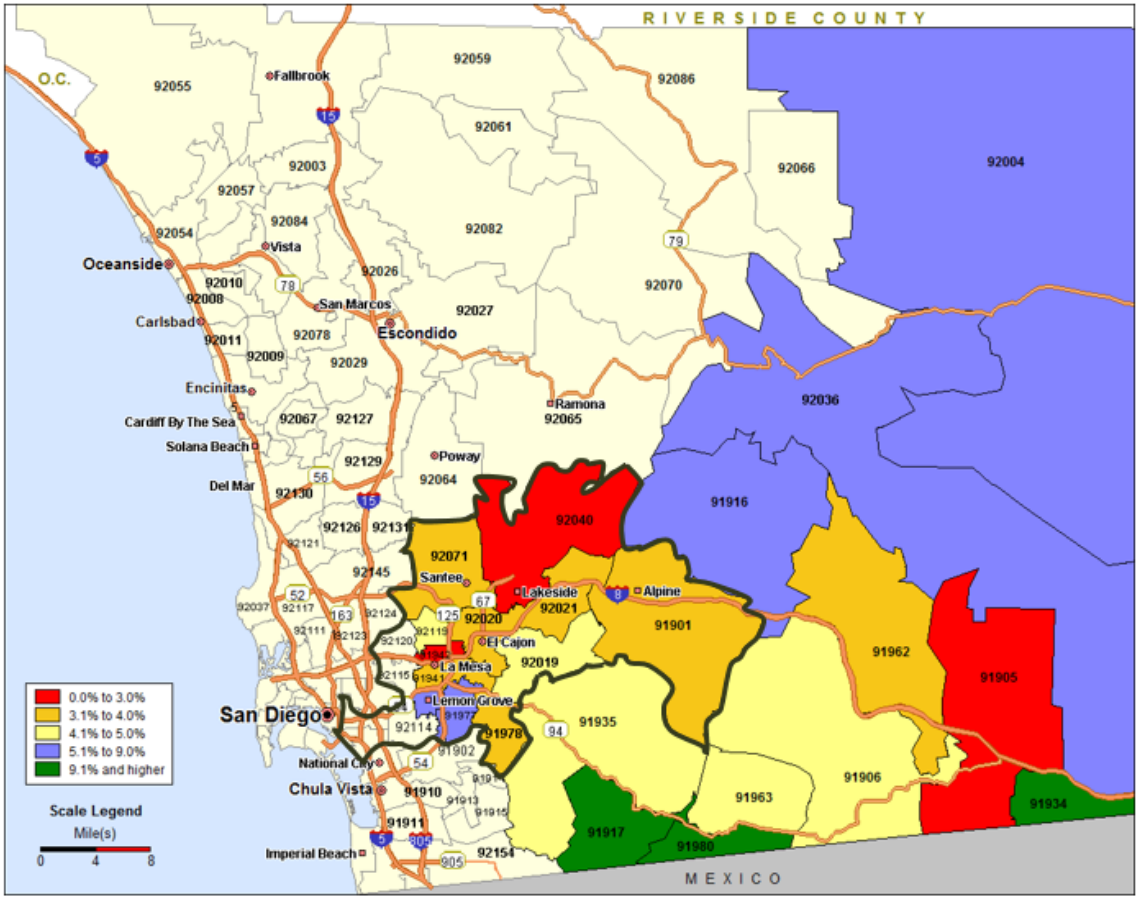
SHARP

SHARP

East County Region Population Growth: 2016−2021

East County's total 2016 population is estimated at 513,224

East County's population is projected to grow 4.1% to 534,047



Data Sources: SpeedTrack, Inc; US Census Bureau

Sharp Grossmont Hospital Service Area Map

Based on fiscal year 2016 inpatient discharges

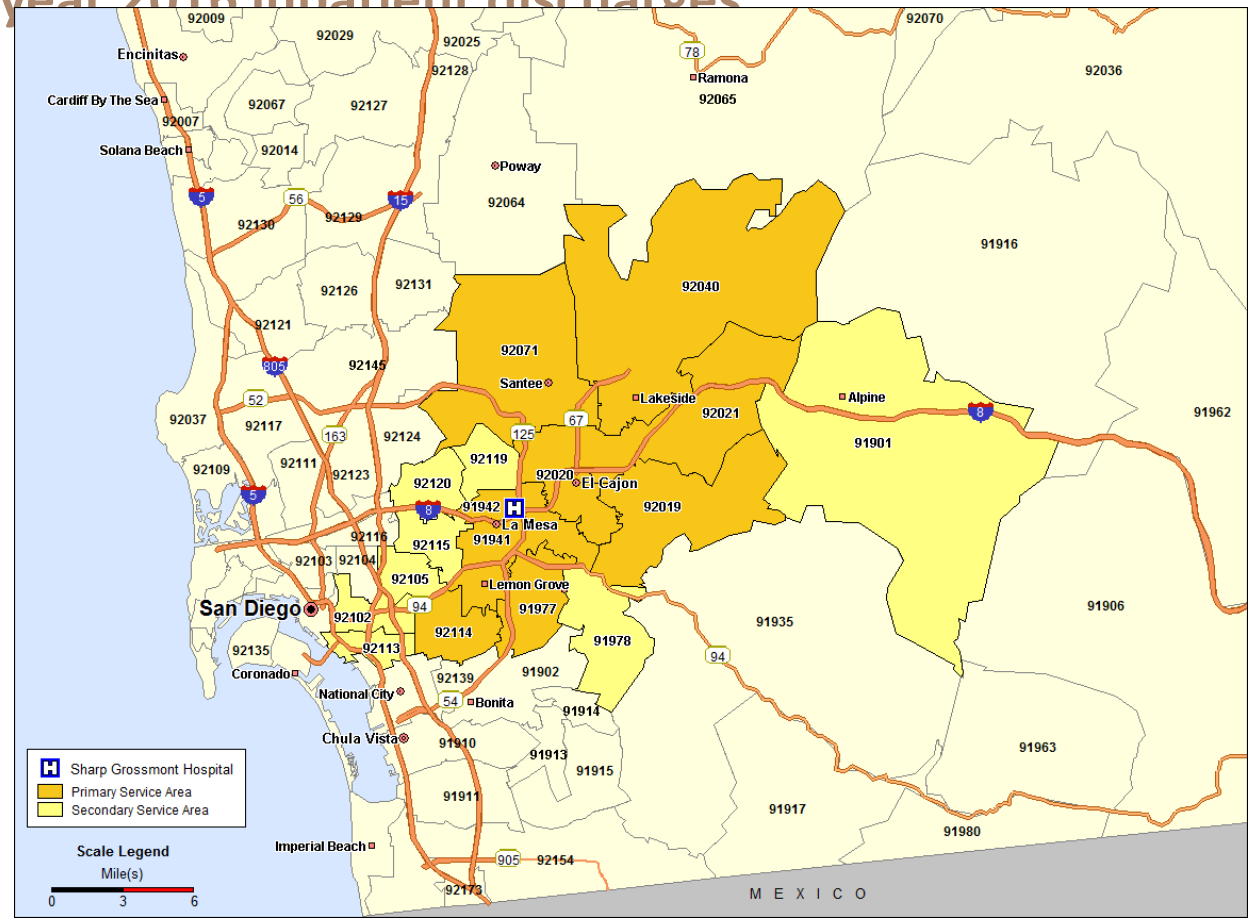
65%

Primary Service Area	
91941	La Mesa
91942	La Mesa
91945	Lemon Grove
91977	Spring Valley
92019	El Cajon
92020	El Cajon
92021	El Cajon
92040	Lakeside
92071	Santee
92114	Encanto**

15%

Secondary Service Area	
91901	Alpine
91978	Spring Valley
92102	East San Diego*
92105	City Heights
92113	Southeast San Diego*
92115	College Area
92119	San Carlos
92120	Grantville

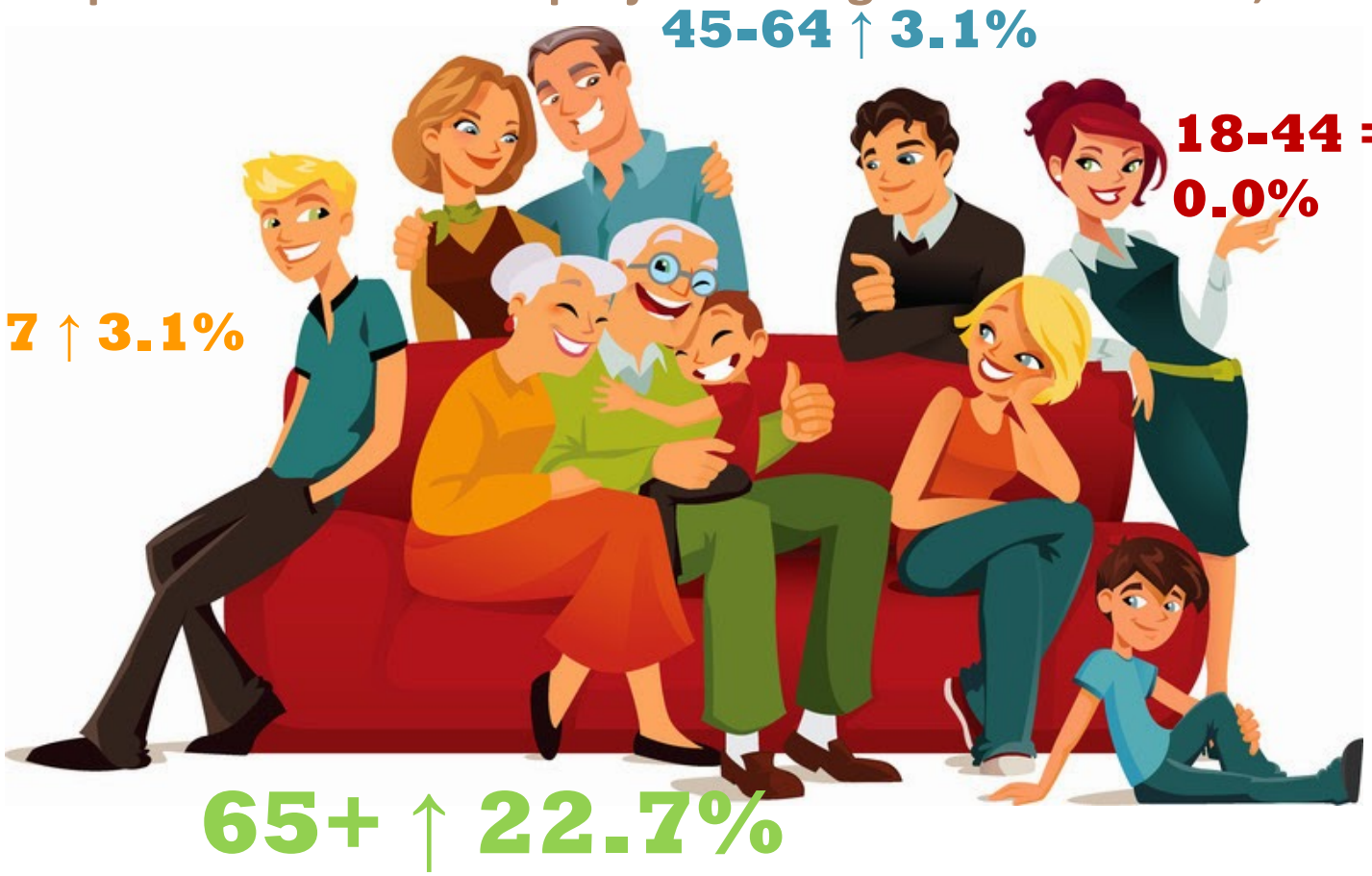
**New to Service Area*
***Moved from SSA*



Data Source: IDX (internal) database

Hospital Service Area Distribution of Growth: 2016–2021

The hospital service area is projected to grow 4.3% to 853,290



Data Sources: SpeedTrack, Inc; US Census Bureau

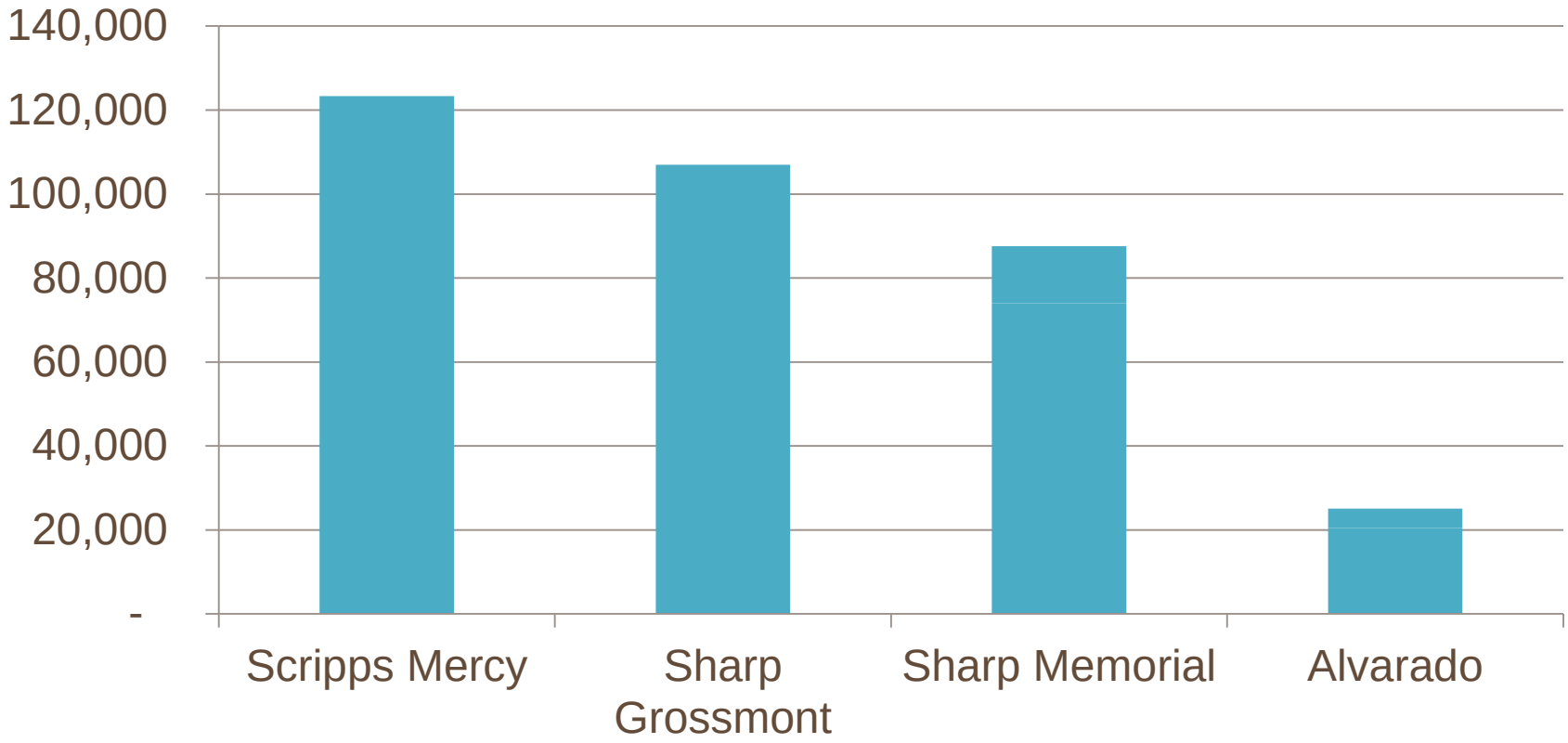
Sharp Grossmont Hospital Service Area Demographic Profile: 2016–2021

Race/ Ethnicity	2016 Population	2016 Percentage of Total	2021 Population	2021 Percentage of Total	2016-2021 Change	2016-2021 % Change
White	356,154	43.6%	359,294	42.1%	3,140	0.9%
Hispanic	287,566	35.2%	310,426	36.4%	22,860	7.9%
Asian/Pacific Islander	68,863	8.4%	73,229	8.6%	4,366	6.3%
Black	71,056	8.7%	73,245	8.6%	2,189	2.6%
Multiracial	27,469	3.4%	31,289	3.7%	3,820	13.9%
Native American	4,090	0.5%	4,300	0.5%	210	5.1%
Other	1,507	0.2%	1,507	0.2%	0 0%	0%
Total	816,705		853,290			

Data Sources: SpeedTrack, Inc; US Census Bureau

Emergency Department Utilization: 2015

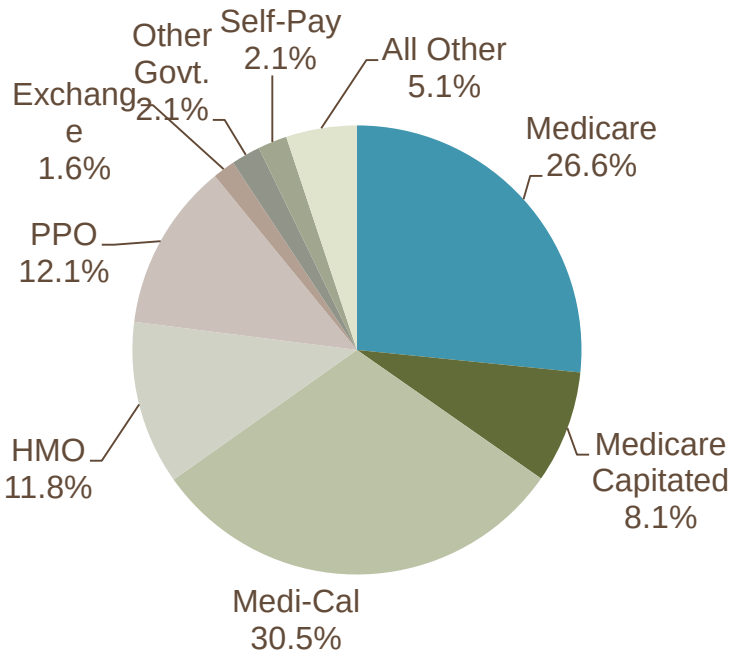
Sharp Grossmont Hospital has one of the busiest emergency departments in San Diego County



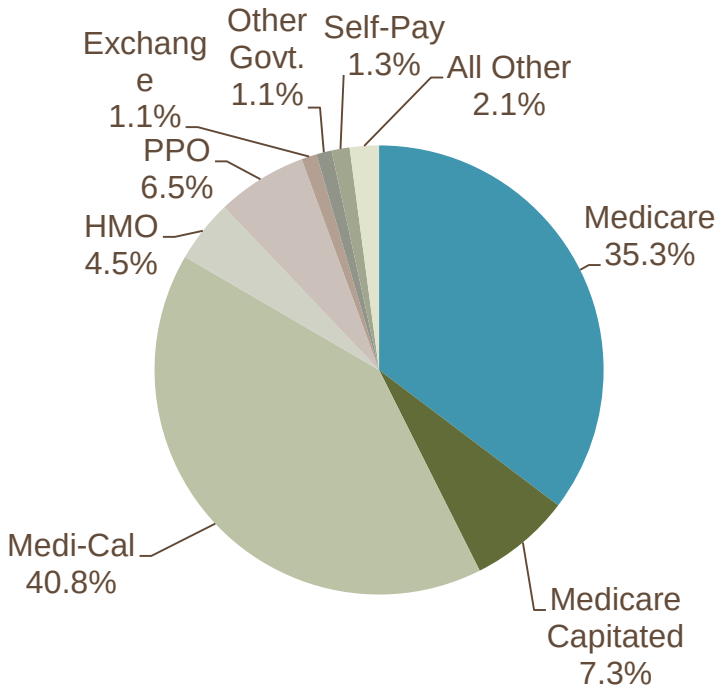
Data Sources: OSHPD Inpatient Hospital Discharge Data

Hospital Payor Mix by Discharge (Fiscal 2016)

Sharp HealthCare



Sharp Grossmont Hospital

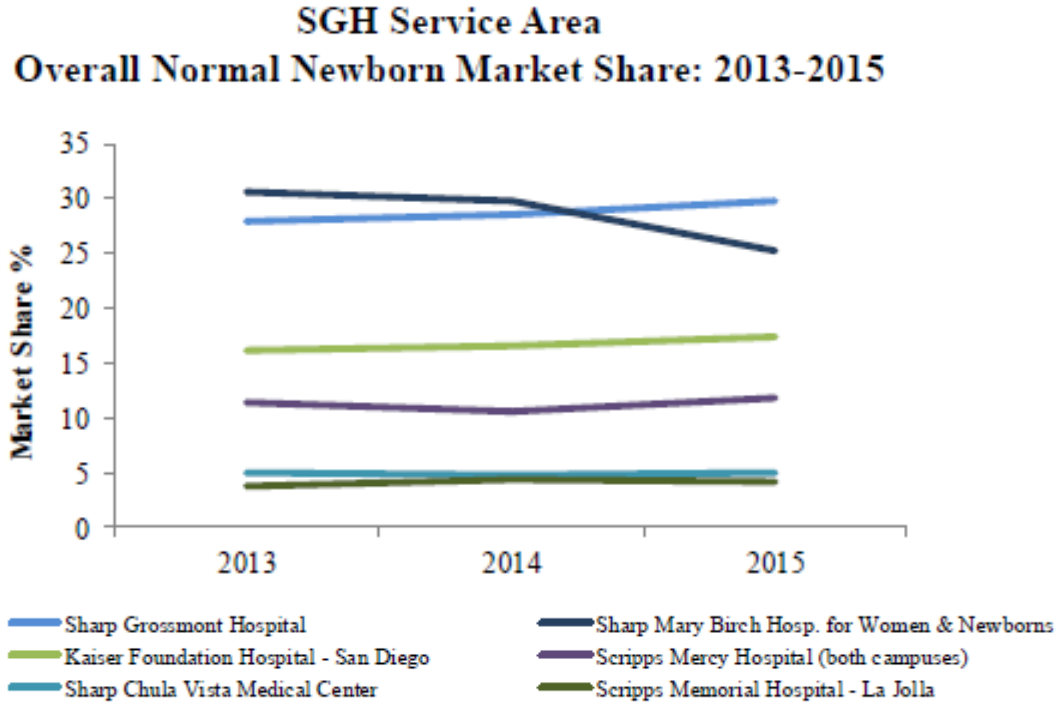


As a percent of discharges, Sharp Grossmont Hospital sees more Medi-Cal and Medicare than the Sharp system average, and less HMO and PPO

Data Sources: OSHPD Inpatient Hospital Discharge Data

Hospital Service Area Distribution of Normal Newborns

Birth volumes in the hospital service area decreased each of the last three years, but Sharp Grossmont Hospital gained normal newborn market share over the period



Data Sources: OSHPD Inpatient Hospital Discharge Data; SpeedTrack, Inc. CUPID

Top 10 Strategic Challenges

As ranked by Sharp Grossmont's Board and Executives (06/20/2017)

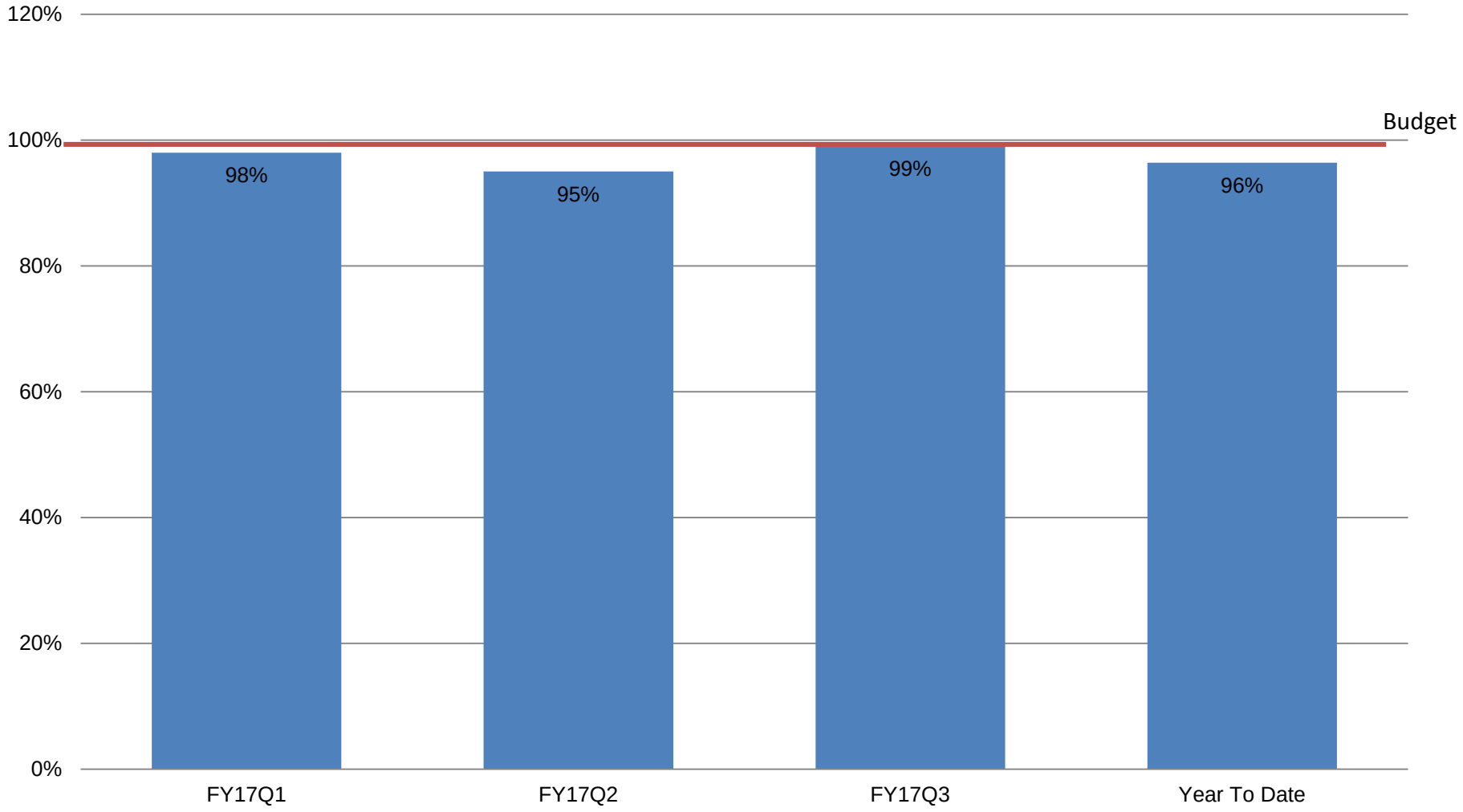
1. Primary care physician shortage in East County
2. Unfavorable shifts in payor mix
3. Health care reform *
4. Operational costs outpacing revenue growth *
5. Emergency room volume
6. Emergency room call and specialty coverage
7. Difficult subsets of East County patient populations
8. Capacity issues/patient access *
9. Unfunded legislative mandates
10. Succession planning for medical staff *

*** Top 10 strategic challenge for Sharp HealthCare system**

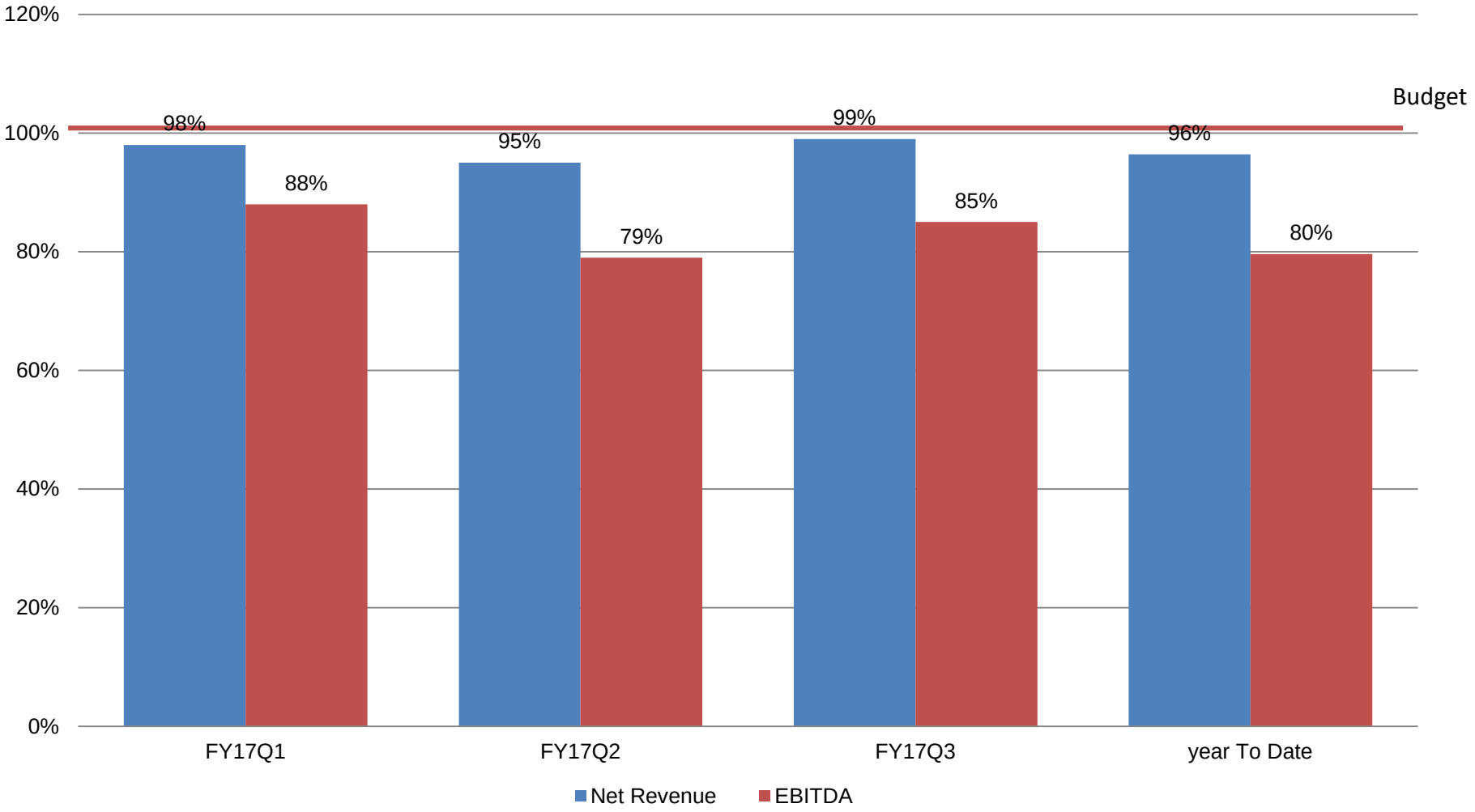
Financial Report

Daniel Kindron
Chief Financial Officer

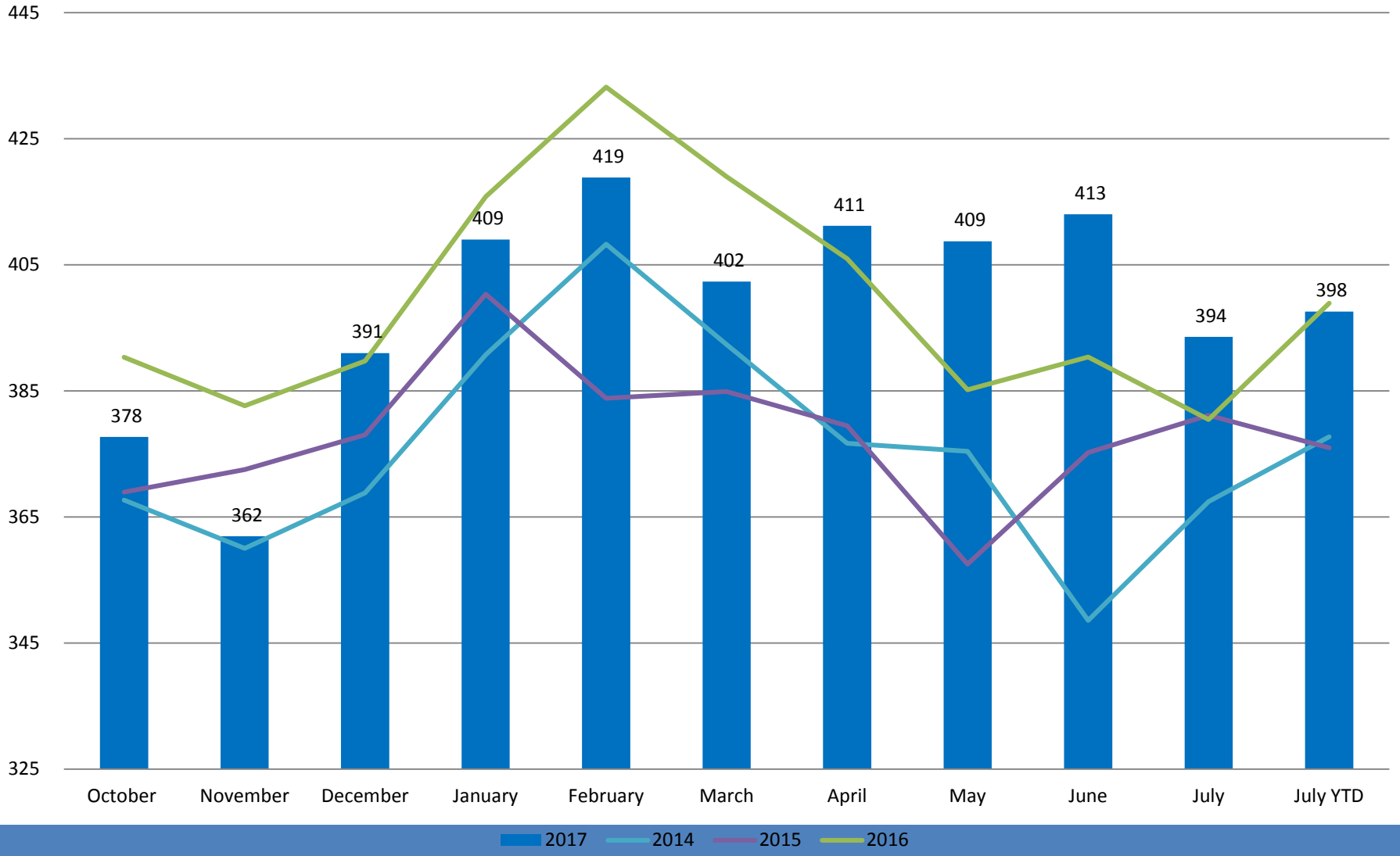
Sharp Grossmont Hospital
Actual Net Patient Revenue as a % of Budget



Sharp Grossmont Hospital
Actual Net Patient Revenue and EBITDA as a % of Budget

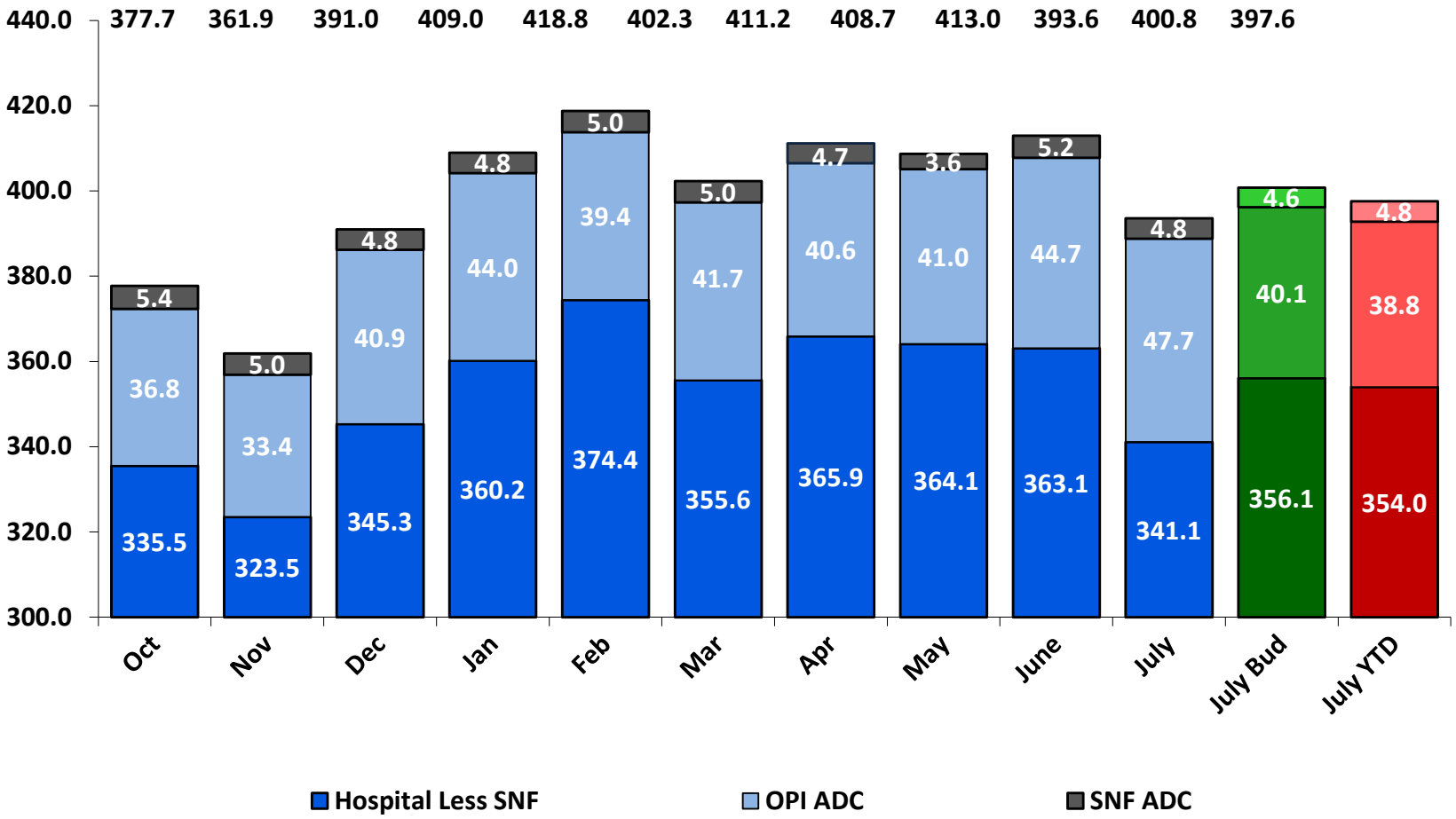


Sharp Grossmont Hospital
Acute Care Beds (Inpatient + Observation Average Daily Census)

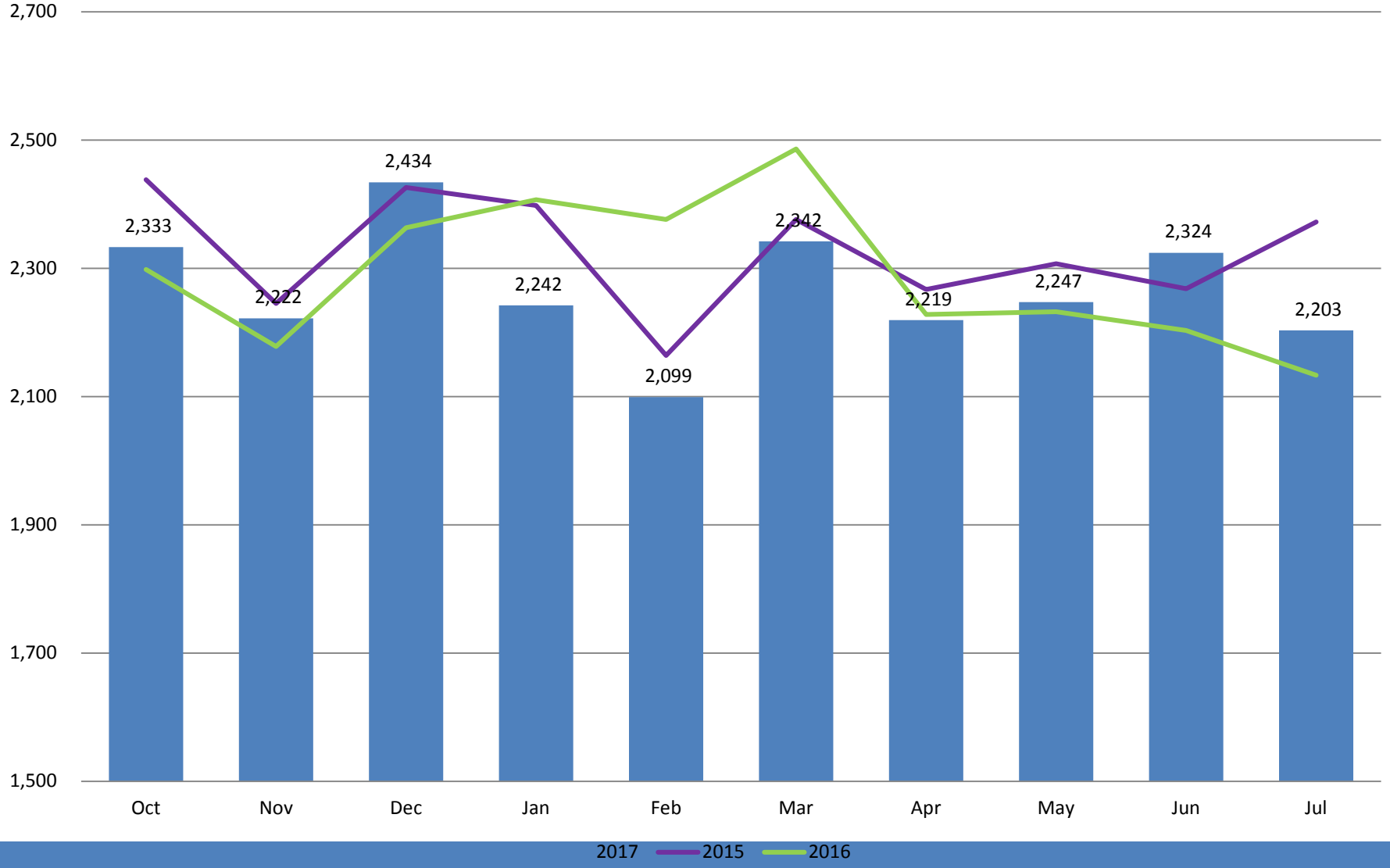


SHARP

Average Daily Census



Sharp Grossmont Hospital
Inpatient Discharges



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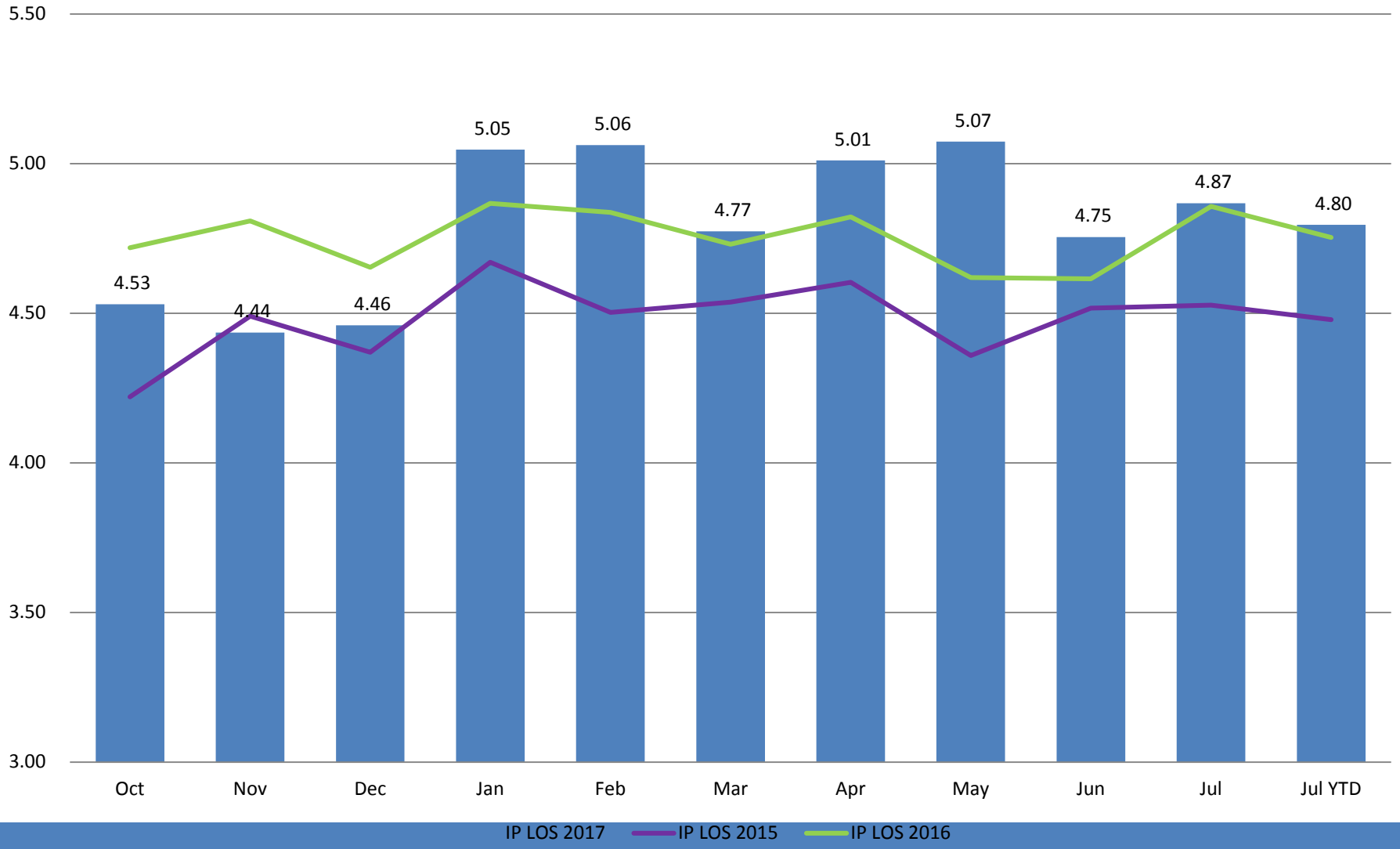
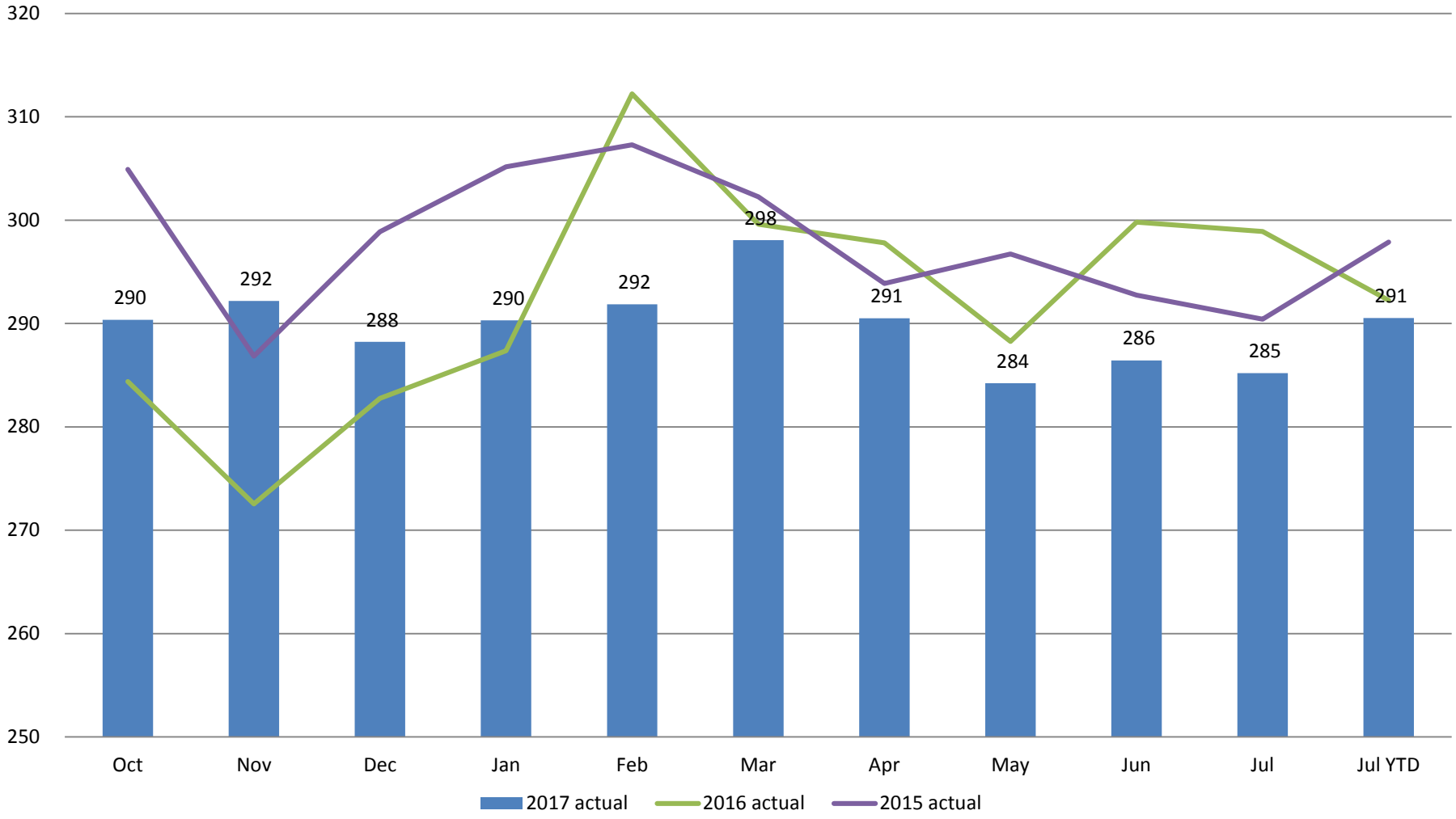
Sharp Grossmont Hospital
Inpatient Length of Stay

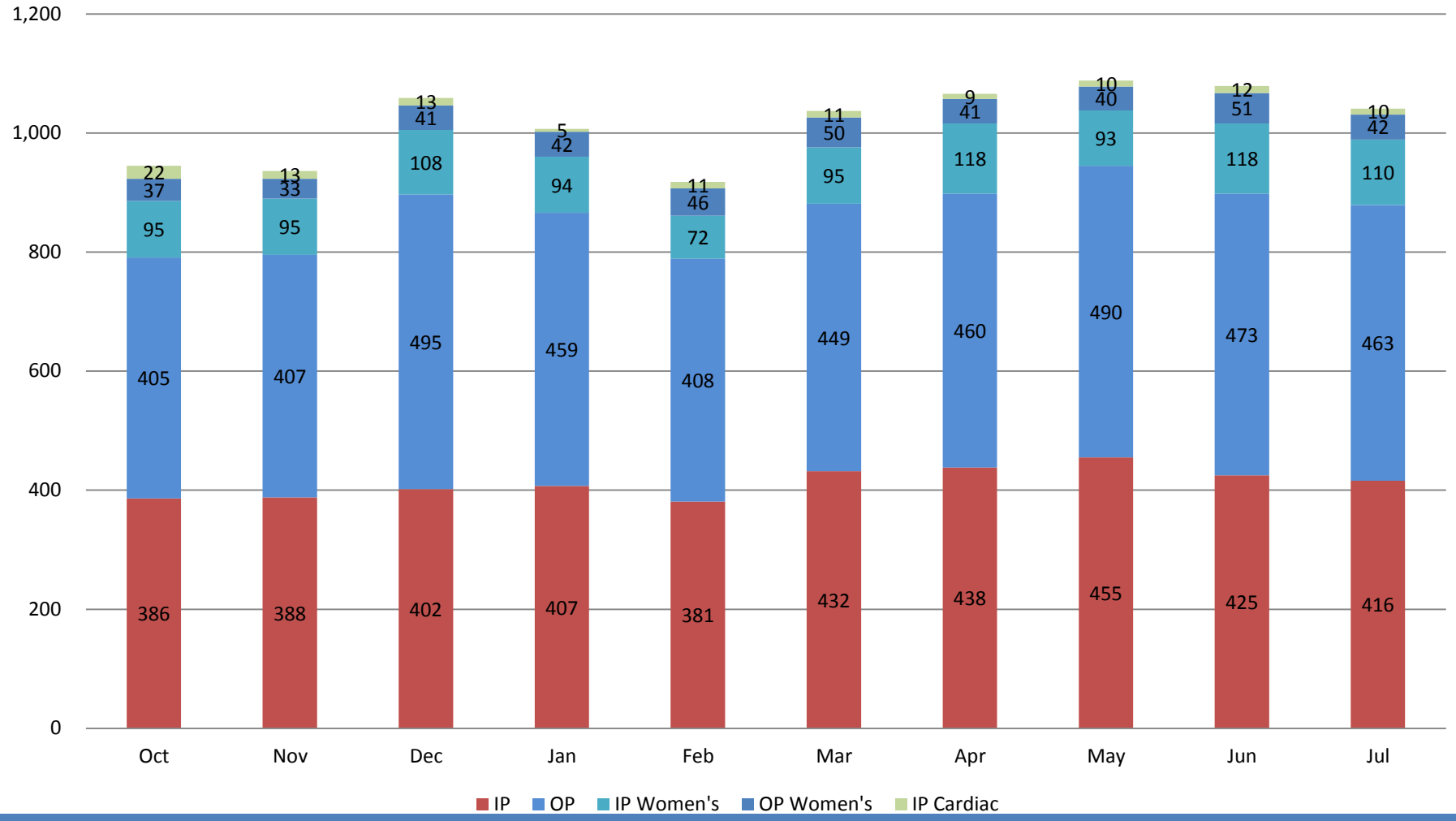


SHARP

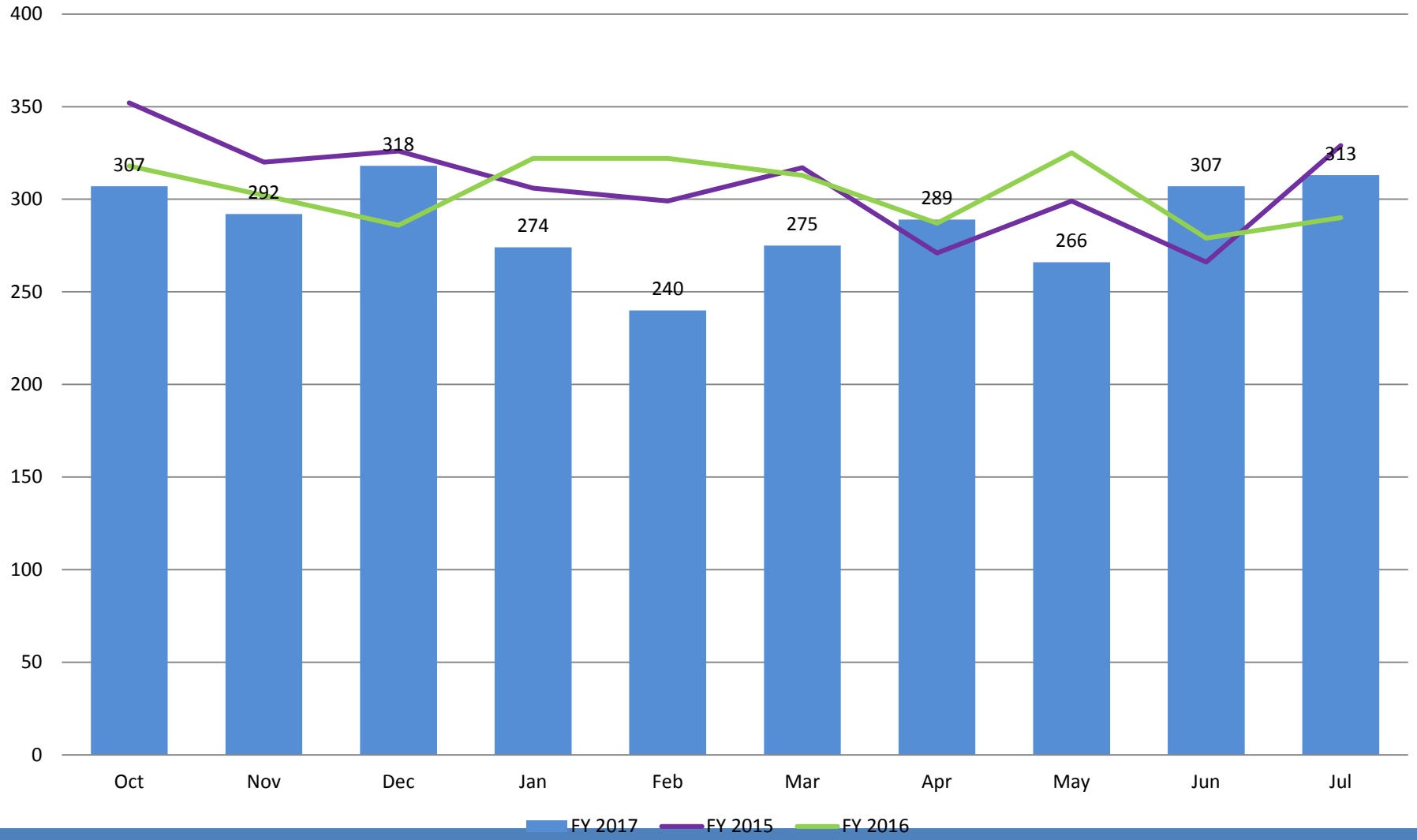
Sharp Grossmont Hospital
Daily Average ED visits



Sharp Grossmont Hospital
Total Surgery Cases



Sharp Grossmont Hospital
Total Newborn Deliveries per Month



Financial Overview

- Shifting Payor mix / Declining Reimbursement
- Continued High Volume (Heads In Beds)
  - Volume Trends (IP vs. Obs)
  - Flat Surgical and Emergency Department Volume
- Cost Control / Cost Structure
- Creating Sufficient Operating MarginsTo Support our Capital Needs

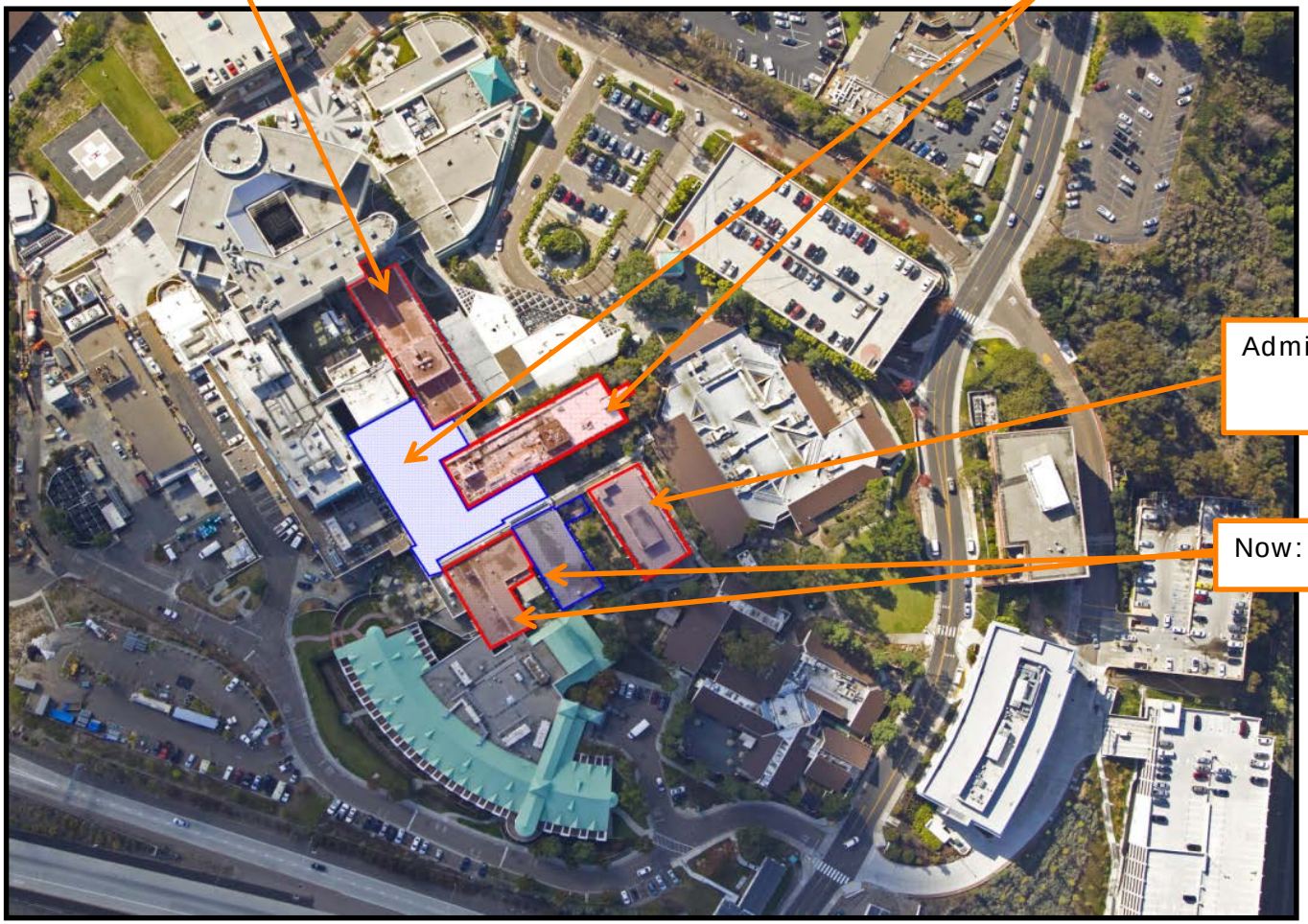
Facilities Planning

Anthony D’Amico
Chief Operating Officer

Our History

SHARP

The heart of the campus is SPC-2



Accomplishments for FY 17

Capital Projects > One Million Financial Summary

Name	Project Budget	% of Project Complete
Substation Replacement	$ 2,346,856	95 %
Nuc Med /US	$ 3,294,637	100 **%**
Elevator Upgrade	$ 1,538,870	100%
Cath Lab 1	$ 1,187,136	100%
GMP Elevators	$ 1,360,000	98%

Central Energy Plant – Donor Recognition Sign

- The new Central Energy Plant received a generous donation from the Brady Family
- Sign unveiled in mid-December to the Donor

GMP Elevator Modernizations

- Elevator Modernizations are complete with State Elevator Inspections approved.
- New Elevators are faster, smoother, smarter; more reliable.
- Scope includes replacement of elevator lobby flooring.

Before

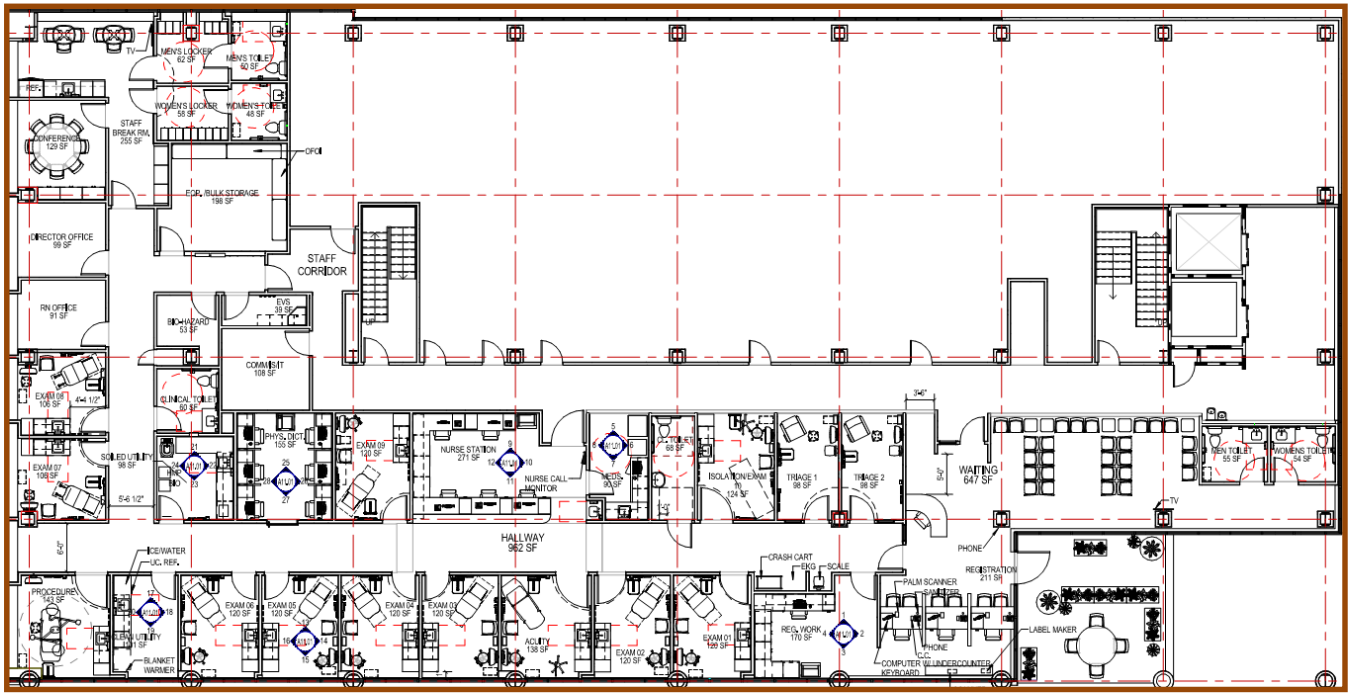
After

Current Facilities Projects

Capital Projects > One Million Financial Summary

Name	Project Budget	% of Project Complete
Care Clinic	$ 3,148,060	65%
ED Imaging Suite	$ 2,530,875	27%
Sleep/ Pulmonary/OIC Remodel	$ 2,398,452	RFP Pending

Care Clinic Facility to GMA



Project Schedule:

	2016		2017											
	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC
BIDDING/ INTERVIEW/ CONTRACT														
PREPARE CONSTRUCTION DOCUMENTS														
CITY OF LA MESA PERMIT REVIEW														
DEMOLITION & CONSTRUCTION														
PUNCHLIST & SUBSTANTIAL COMPLETION														
IT INSTALLATION, TEST & CHECKOUT														
OPERATIONAL														

Care Clinic Construction Progress –August, 2 2017

Main Corridor

Nurse's Station

Typical Exam Room

Typical restroom

ED Imaging Suite Remodel

- Construction Demolition Completed
  - Utilities safe-off
  - Existing Radiology Equipment removed and stored
  - Ceiling removed
  - Walls removed
  - Flooring removed
  - Slab saw cut for new plumbing
  - Temporary HVAC in place
  - New wall framing in progress

Project Schedule:

	2016									2017											
	APR	MAY	JUN	JUL	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEPT	OCT	NOV	DEC
BIDDDING/INTERVIEW/CONTRACT																					
PREPARE CONSTRUCTION DOCUMENTS																					
OSHPD PLAN REVIEW and APPROVAL																					
CONSTRUCTION/PUNCHLIST/CLOSEOUT																					

OIC Expansion at GMT

Current Status

- Proposals are due August 25, 2017
- 2013 California Building Code vs 2016 California Building Code; transition.
- Confirmed addition of real estate to OIC / Pharmacy suite lease (90 SF)
- Targeted Completion end of Q1 FY18

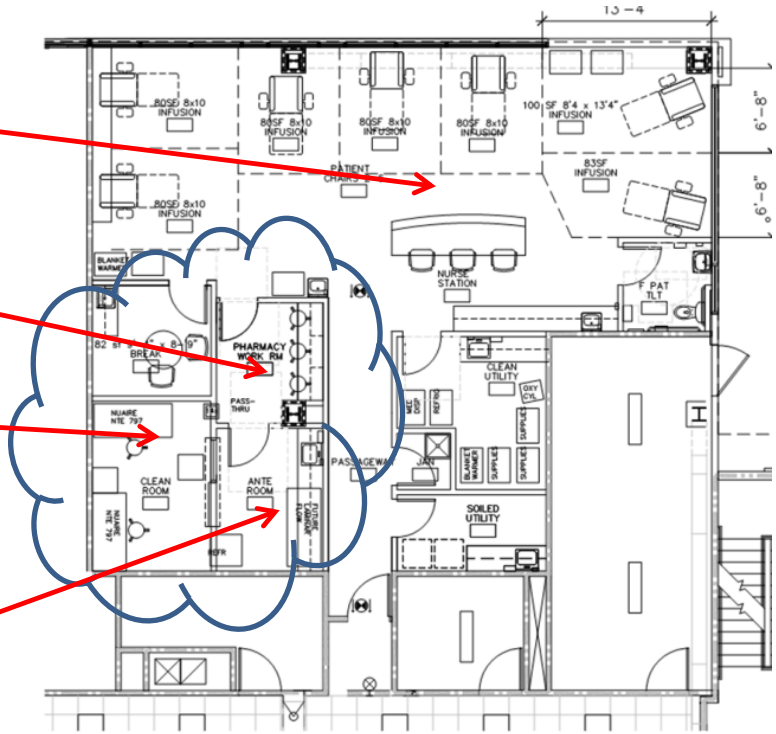
OIC Expansion at GMT

7 chair Outpatient
Infusion Center

Work Room

ISO 5/ 7 Negative pressure Prep Room

ISO 7 Positive Pressure
ante Room USP 800 / 797 regs



GMP Remodel

Sleep/ Pulmonary Expansion and Hospital Clinics

Clinic Program

- ❑ 4 exam , 1 Office
- ❑ 1 ADA Restroom
- ❑ 1 Storage Closet

Shared Areas:

- ❑ Waiting, Nurse's station / Registration
- ❑ Vitals, Soiled & clean utility rooms
- ❑ Lounge, charting, Staff Restrooms

Future Facilities Planning

NAME	PROJECT BUDGET	PROPOSED CONTINGENCY
Women's Center -2 Remodel	$ 3,000,000	$ 200,000
Cancer Center – Remodel	$ 1, 371,000	TBD
Ric-Will Design	$ 1,500,000	TBD
Orthopedic Pods	$ 2,800,000	TBD

Women's Center Second Floor Flooring Project

- Main corridor flooring will be completed in 9 phases.
- Implementation plan finalized
- Pyxis(s) will be relocated prior to start of phase.
- The nurse's stations will be closed for 4 days. The second one will be back up for the one closed.
- Scope: New tile around bases of columns, demo carpet and install new wood look plank flooring.

Base Scope for WC Remodel

Patient Room

- Luxury Vinyl Flooring with border and self cove base
- Refurbished / replaced headwalls
- Completely remodeled restrooms with new walk in showers
- Lighting, blinds, paint, furniture, artwork
- Replace sink and counter
- ADA code compliancy

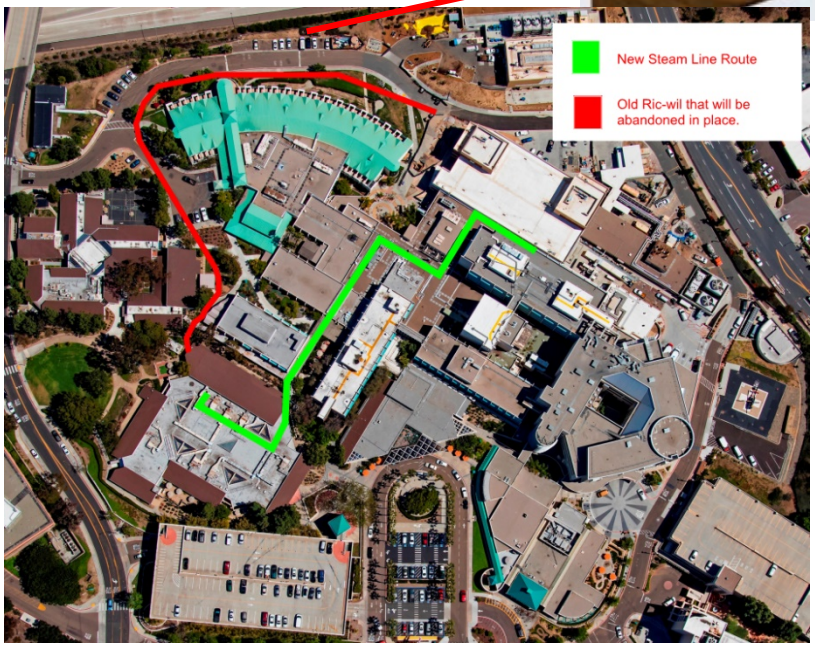
Corridor

- Replace existing nurse's stations with new millwork
- Replace 4 work stations' millwork with new
- Wrap columns, Paint
- Artwork, furniture

Steam Repair Project (Ric-Will)

- Project is in the final stages of design.
  - Will be sent to OSHPD for a rapid review
  - This will not go out as a design build project, but rather a traditional design bid build.
  - All steam lines will be run from the H&V, over the roof, to physical rehab and behavioral health.
  - The RFP should be ready to go out by August.

Old Ric-Will Concept



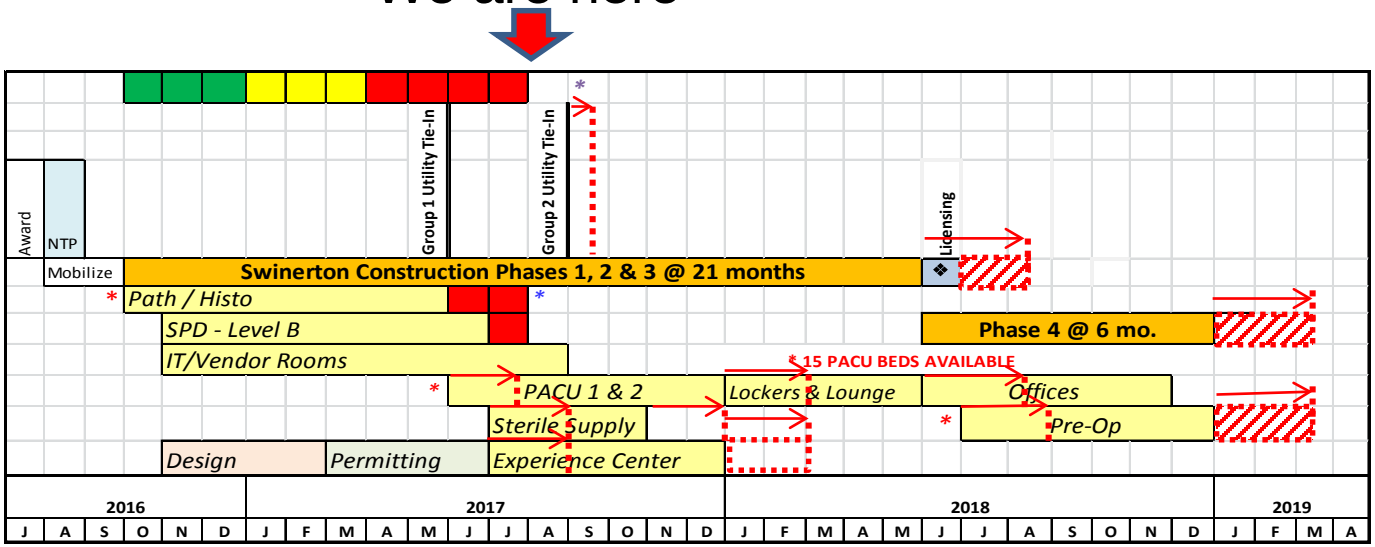
Level 1 Infill Progress Report

Budget

Infill Budget					
Project Budget	Invoice to date Project	% of Project Complete	Contingency Budget	Forecast Pending COs	Remaining Contingency
$ 54,923,511	$ 14,697,994	35%	$ 3,816,590	$ 2,680,814	$ 1,135,776

Level 1 Infill-Schedule

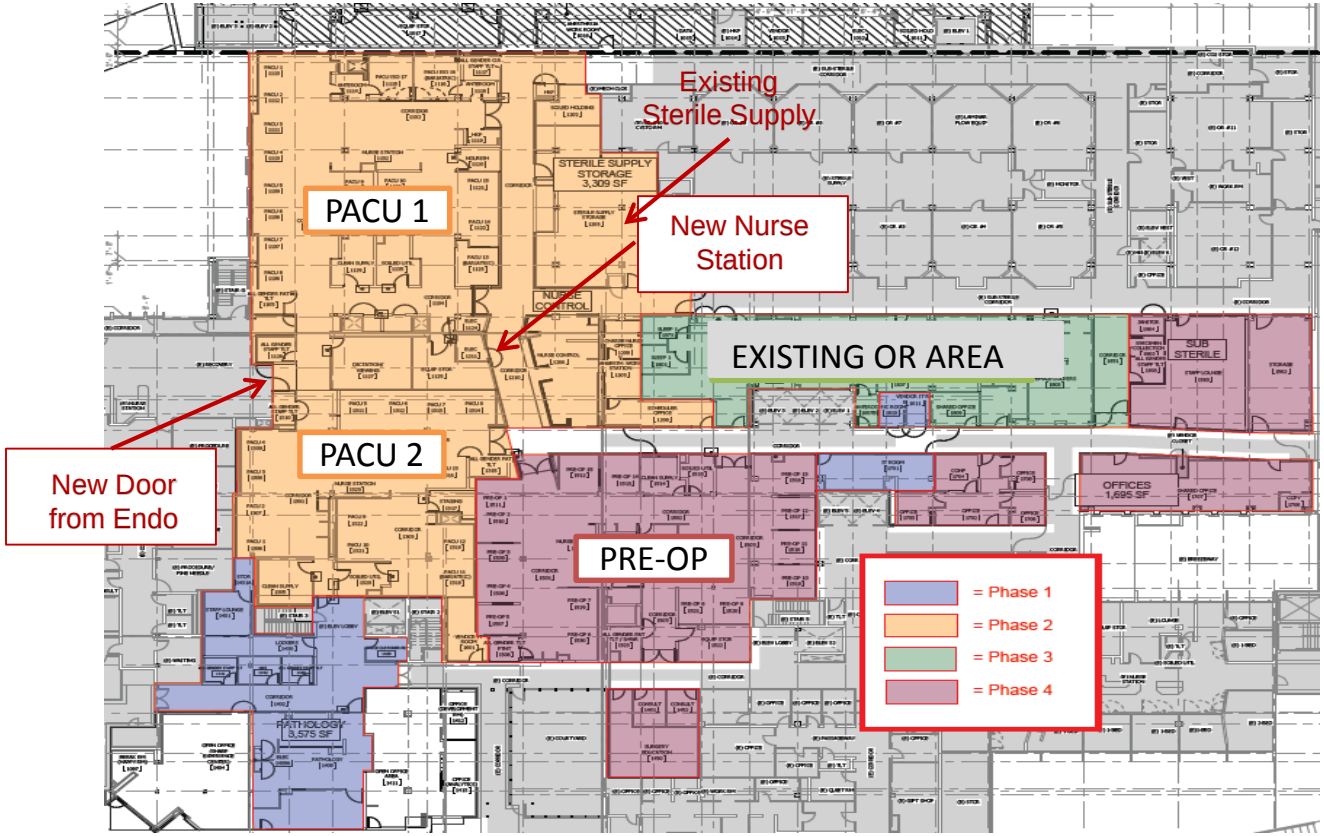
We are here



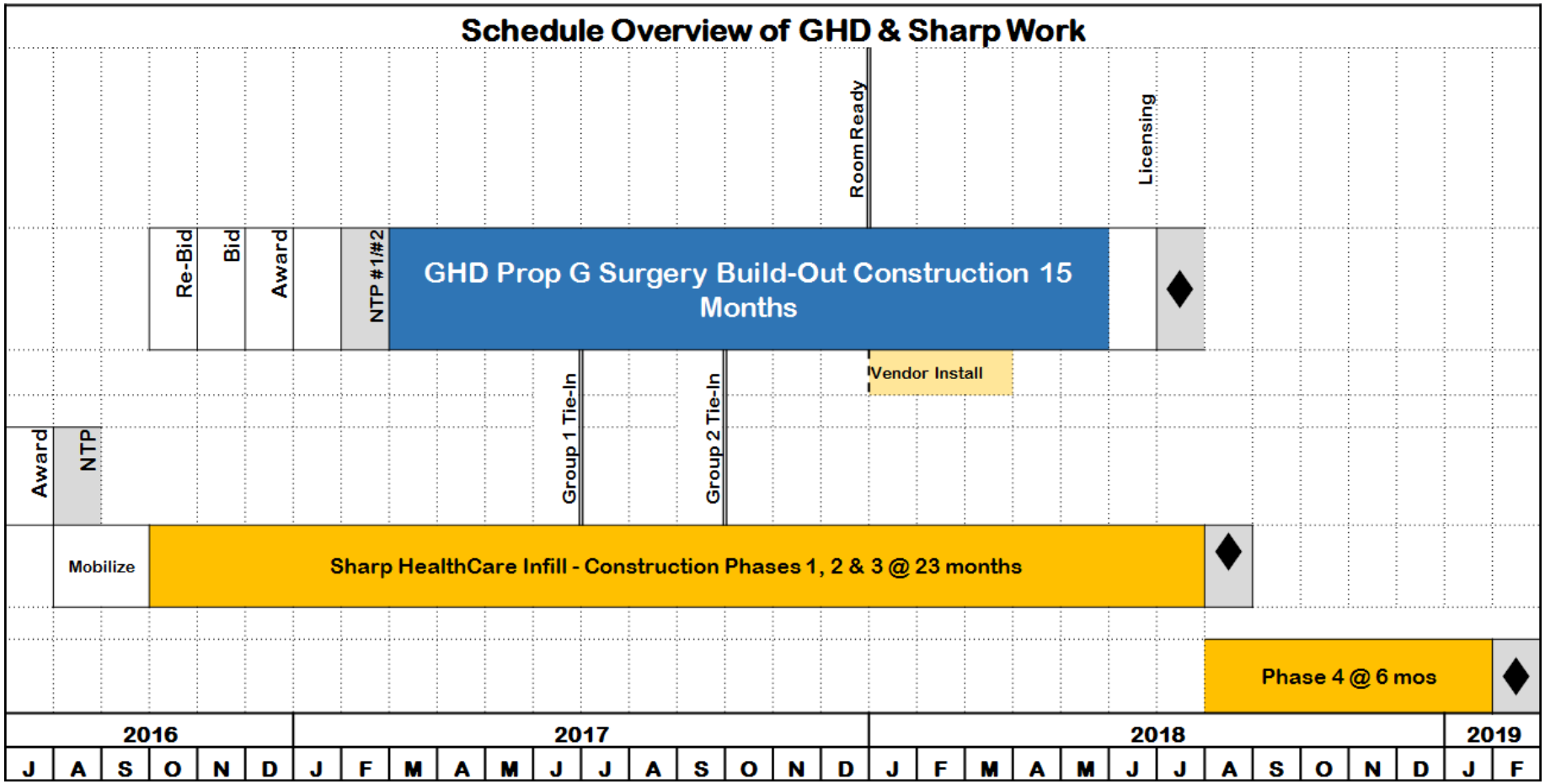
- Currently ~ forty one (41) workdays behind.
- Correcting unforeseen issues places schedule on red.
- Phase 1 incurred a delta of *41 workdays* due to prior loss of time in Pathology/Histology which is critical path.
- Modify the completion of the Steam System timeline installation to match the Group 2 Utility Tie-ins by September 14, 2017 which are required to serve PACU 1 and 2.

** Critical Path*

Level 1 Phasing Plan Overview



Combined Project Schedules



Level 1 Infill-Construction

- Pathology Department relocate into their new space on July 20, 2017 and opened the former Lab/Pharmacy entry corridor on July 21, 2017.
- Start Phase 2 construction Infection Control barrier build.
- Complete install of anchors for the data rack for the IT rooms on Level 1; occupancy projected for August 14, 2017.
- Continue with the mechanical system install in the IT room.

IS equipment install in Grossing Lab

Moving Pathology Dept. into New Space

Nursing Report and Patient Initiatives

Louise White
Vice President, Patient Care Services

SHARP

People Initiatives

Molding the Sharp Grossmont Culture

New Employee Introductions

Employee Forum

RELIABILITY HUDDLE SHEET

THE SHARP EXPERIENCE

Leadership Forum

YOUnity

MAGNET Designation

2006-2010

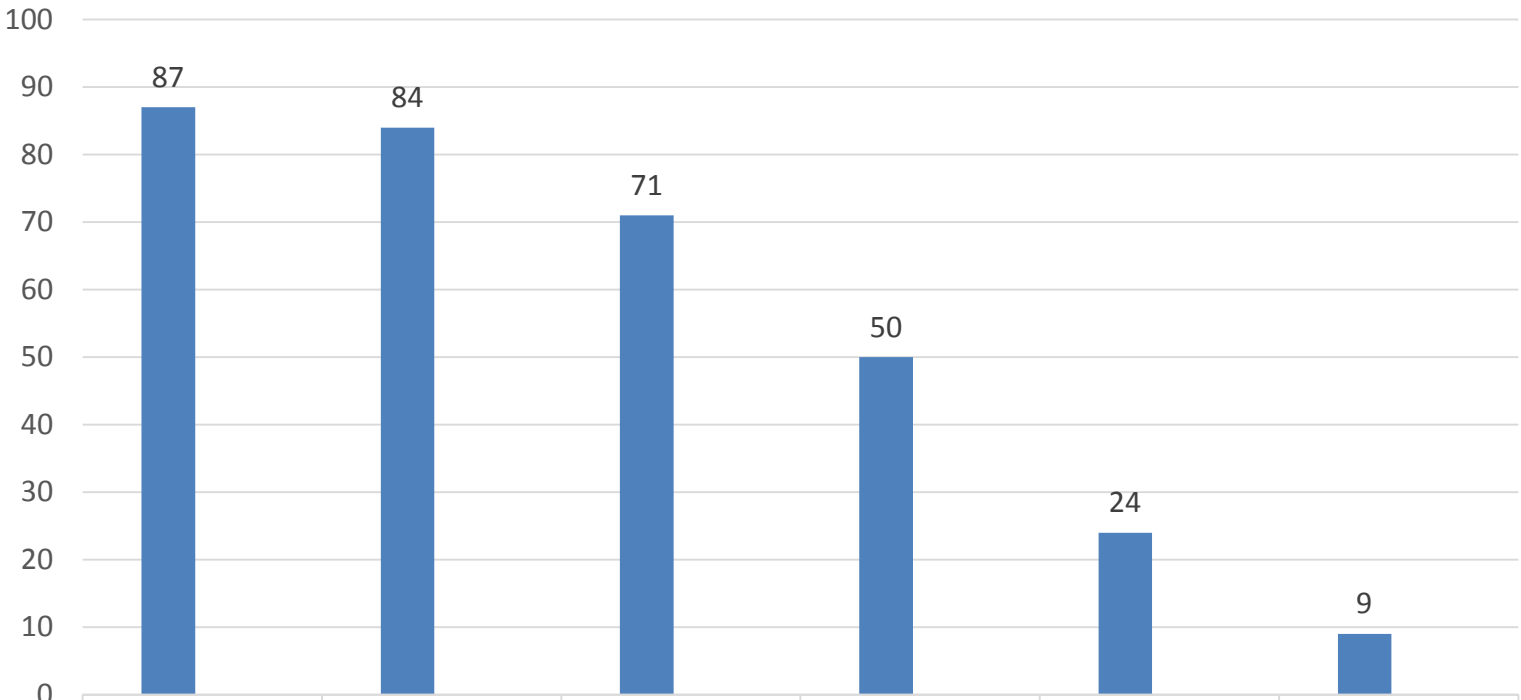
2011-2015

2017-2021

Magnet recognizes Sharp Grossmont nurses with three exemplars:

- Transition of Care program
- Behavioral Health Admission screening
- Advanced Illness Management

Patient Satisfaction Overall Percentile Rank



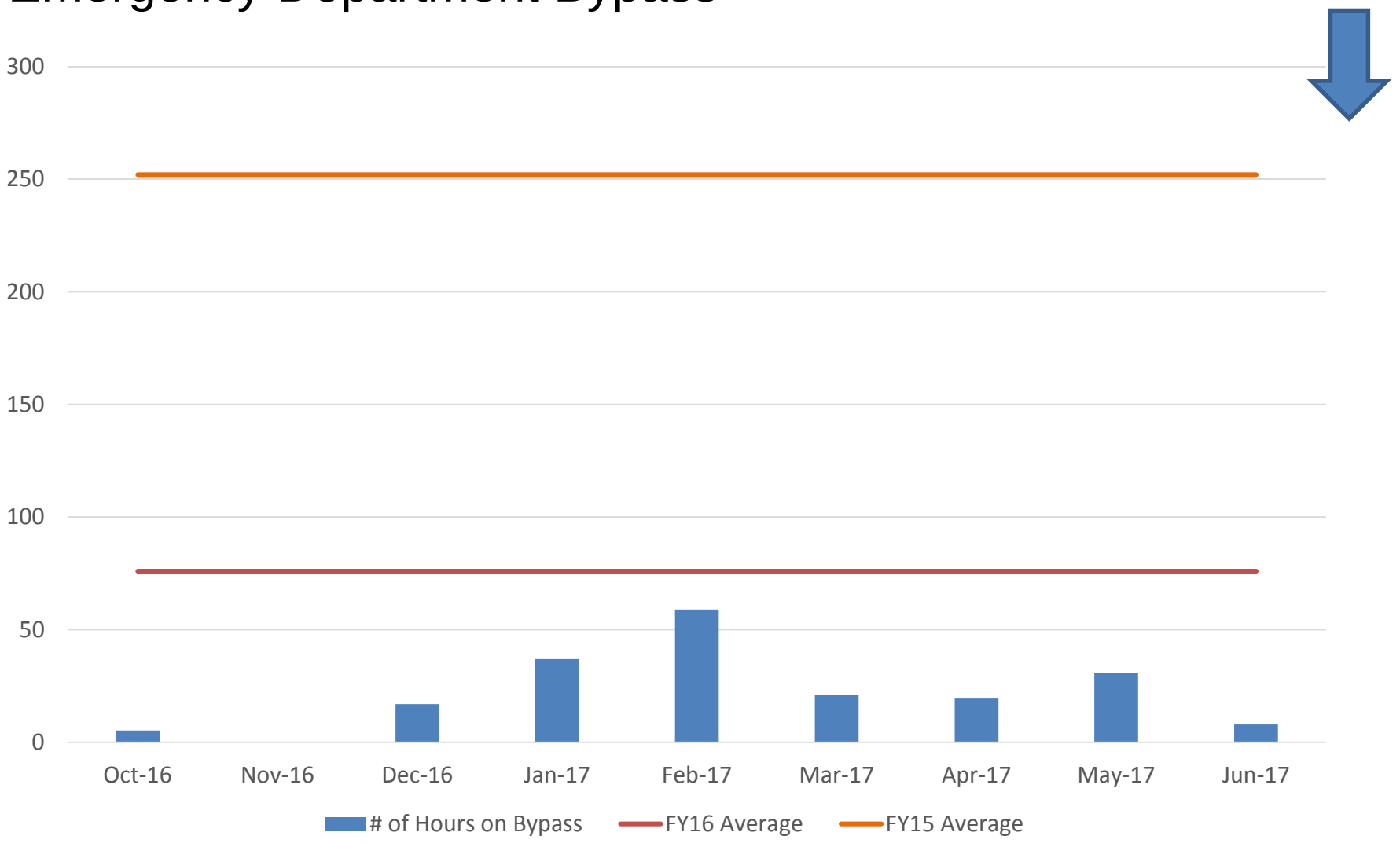
	Womens' Center	Inpatient Behavioral	West Tower	North/South Tower	East Tower	Emergency Department
Overall Percentile Rank	87	84	71	50	24	9
# of Respondents	293	406	624	262	789	1634

Surveys Received Between : FY17Q1-FY17Q3

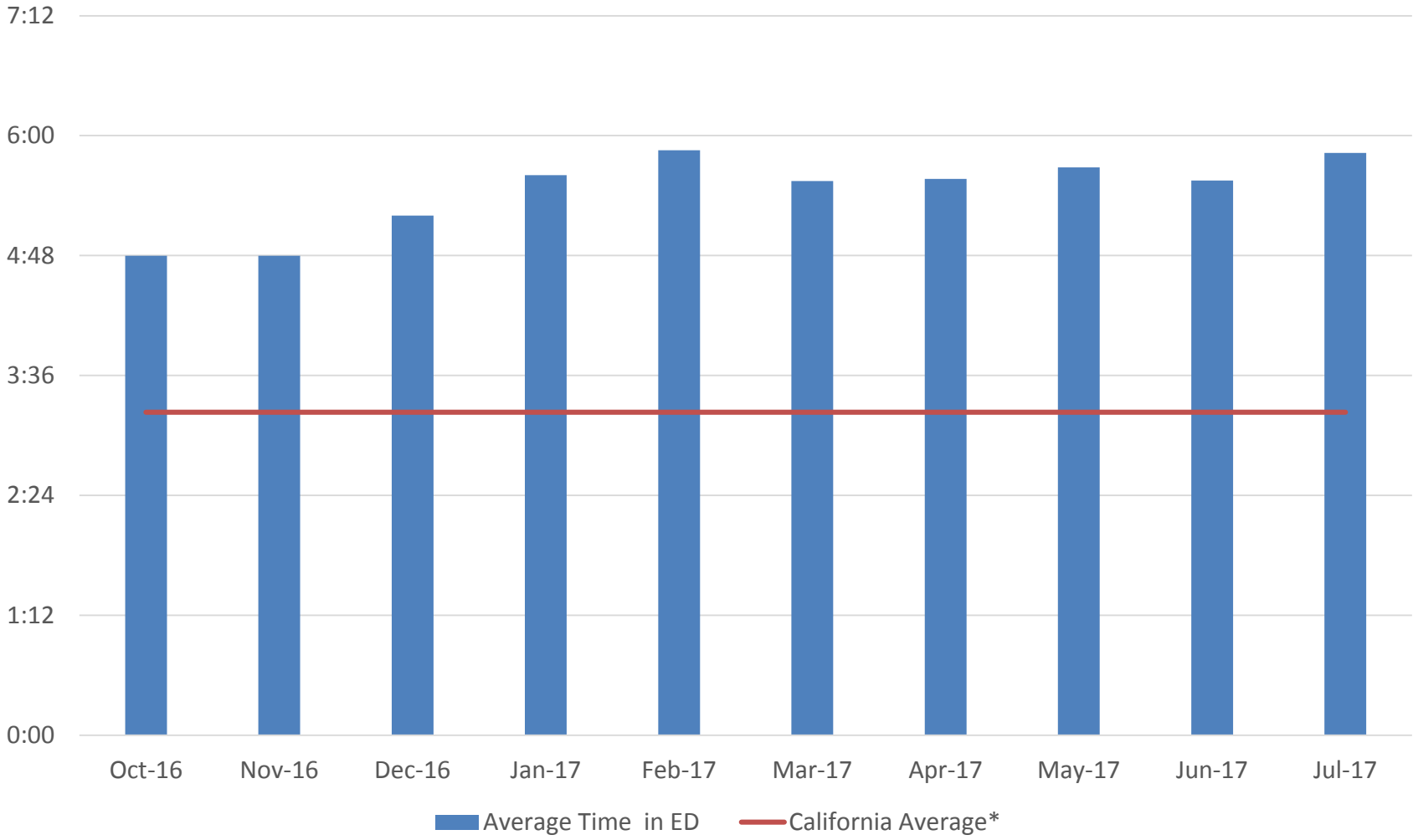
Emergency Department

Emergency Department Bypass

Lower is Better



Emergency Department Outpatient Visit Wait Time

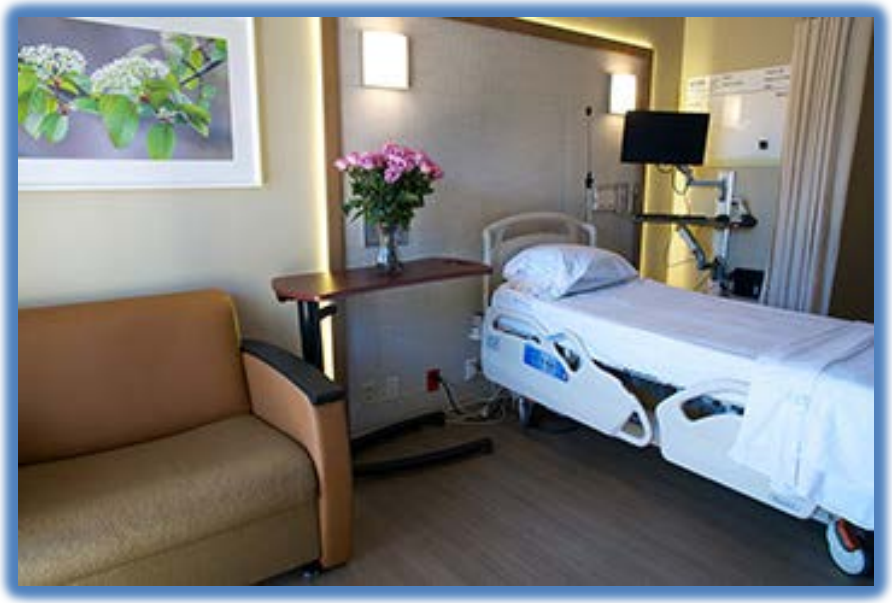


* Based on current Medicare.gov Hospital Compare Website

Emergency Department Initiatives

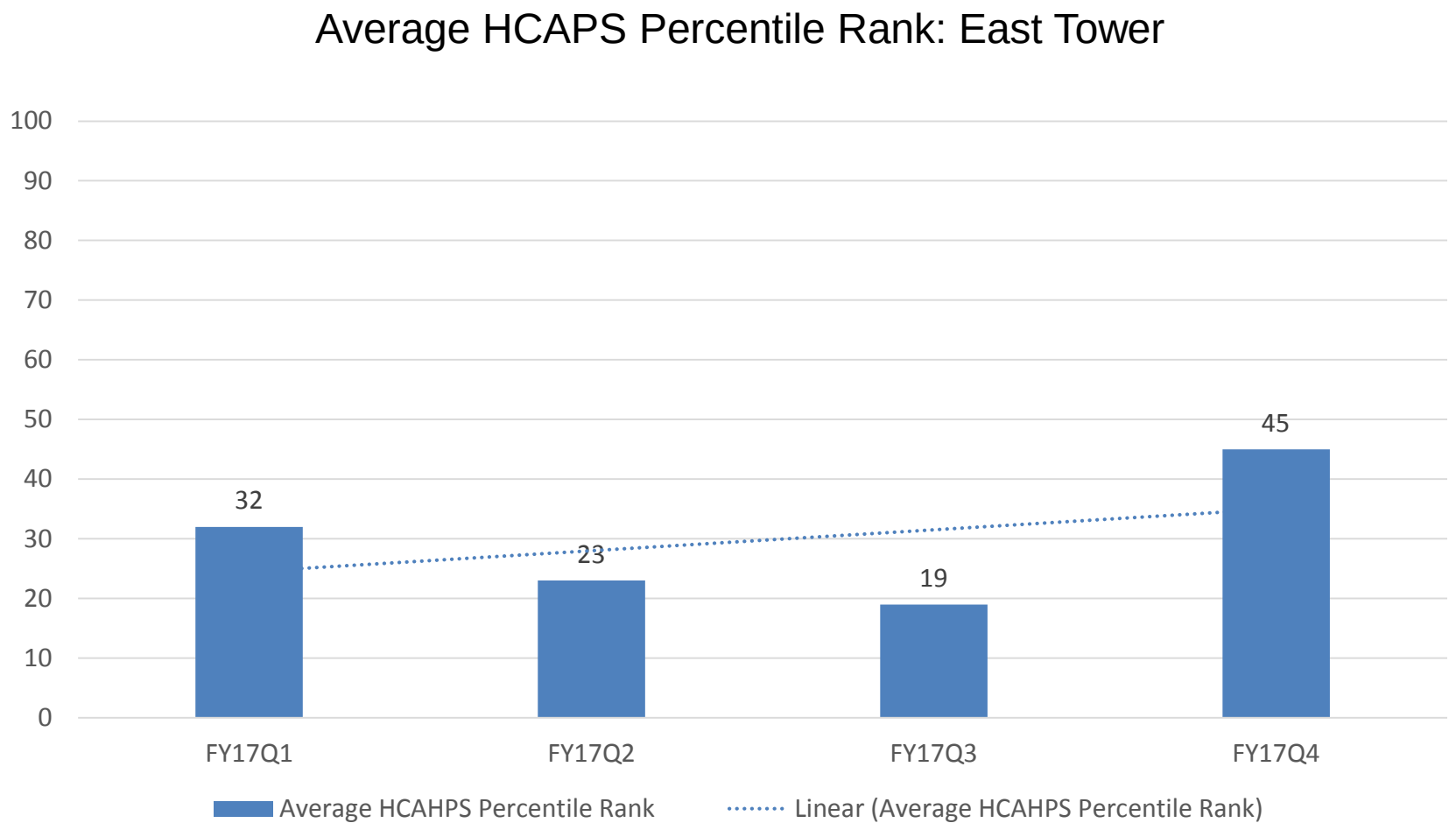
- **ED new leadership team started April 2017**
- **Team Health consulting initiative also started April 2017**
- **Patient experience improvements**
  - **Planned 18-month project to re-engineer throughput process**
  - **Discharge phone calls**

East Tower Challenge
Improving the Patient Experience



- **4-East Leadership**
- **Nurses Aide experience training for East Tower**
- **Pain Management program**
- **Medication administration program**
- **No Pass Zone/ Call light expectations**
- **Nose reduction Program**
- **Care Partners**

East Tower Challenge



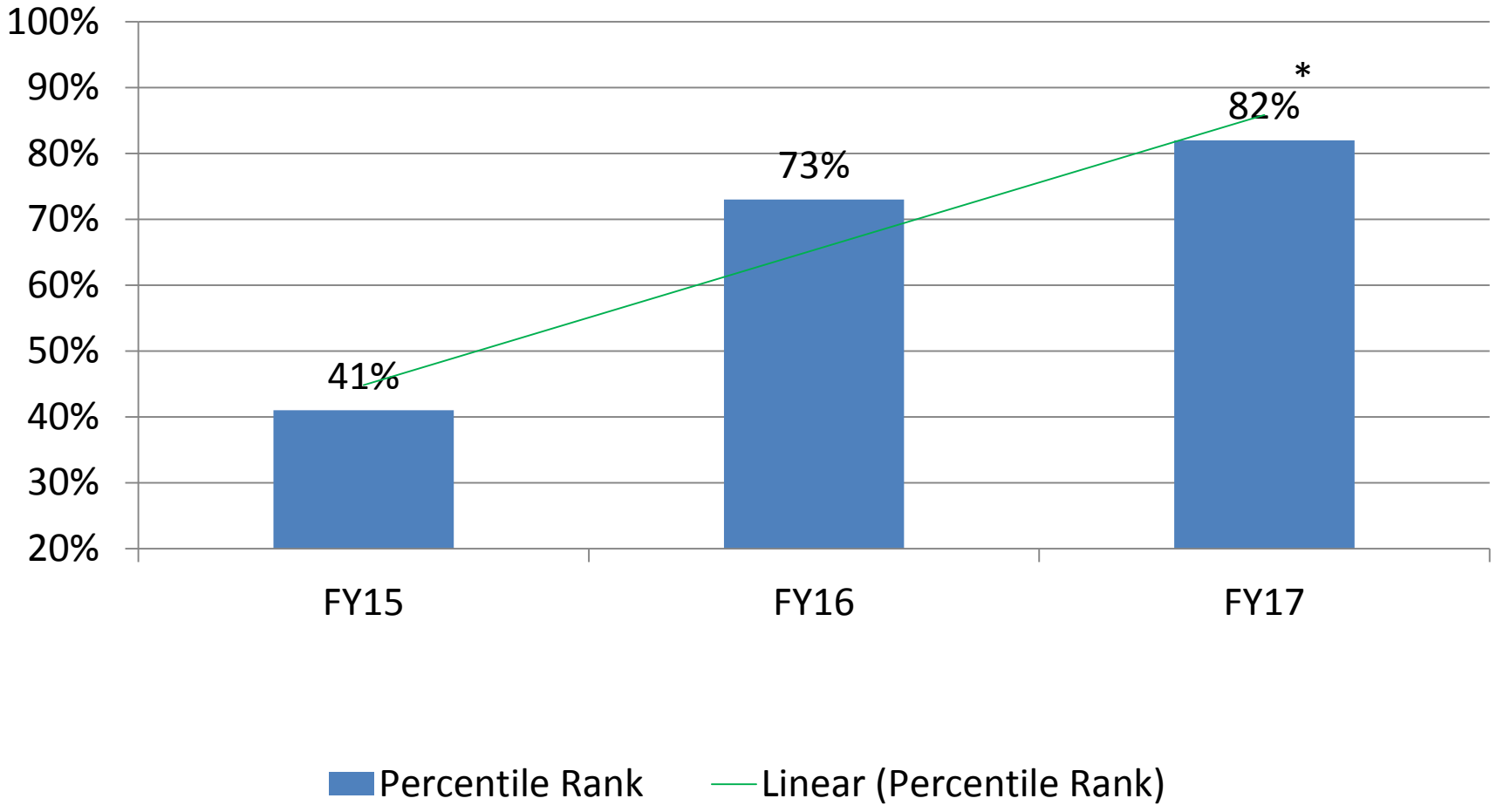
Data Source: Press Ganey

Annual Quality and Safety Report

Nancy Greengold, M.D.
Chief Medical Officer

SHARP

Annual Physician Partnership Survey



*Not finalized until national data available (October 2017).

Physician Activities

- Quarterly “State of the hospital” conferences
- Strong MEC leadership
- Shared Governance meetings
- Monthly CEO and medical staff luncheons
- Administration at supervisory committees
- 1:1 meetings with CEO and CMO
- Steering committees in major service lines
  - E.g., Heart & Vascular
- Cultivating physician leadership

Quality and Safety Focus

Mortality

Average

- Focus on sepsis recognition and management
- Mortality review initiative with Mayo
- Enhancement of Rapid Response Team (RRT)
- Focus on advanced illness management
- New attention to appropriateness criteria

Readmission

Average

- Variety of strategies
- Readmission community collaborative
  - Top 10 SNFs, top 10 home health agencies, 5 Family Health Clinics

Patient Safety Indicators

Average

- HRO training
  - MEC: 100% trained
  - SGH Staff: Approximately 70% trained . Deadline to complete training in December 2017.

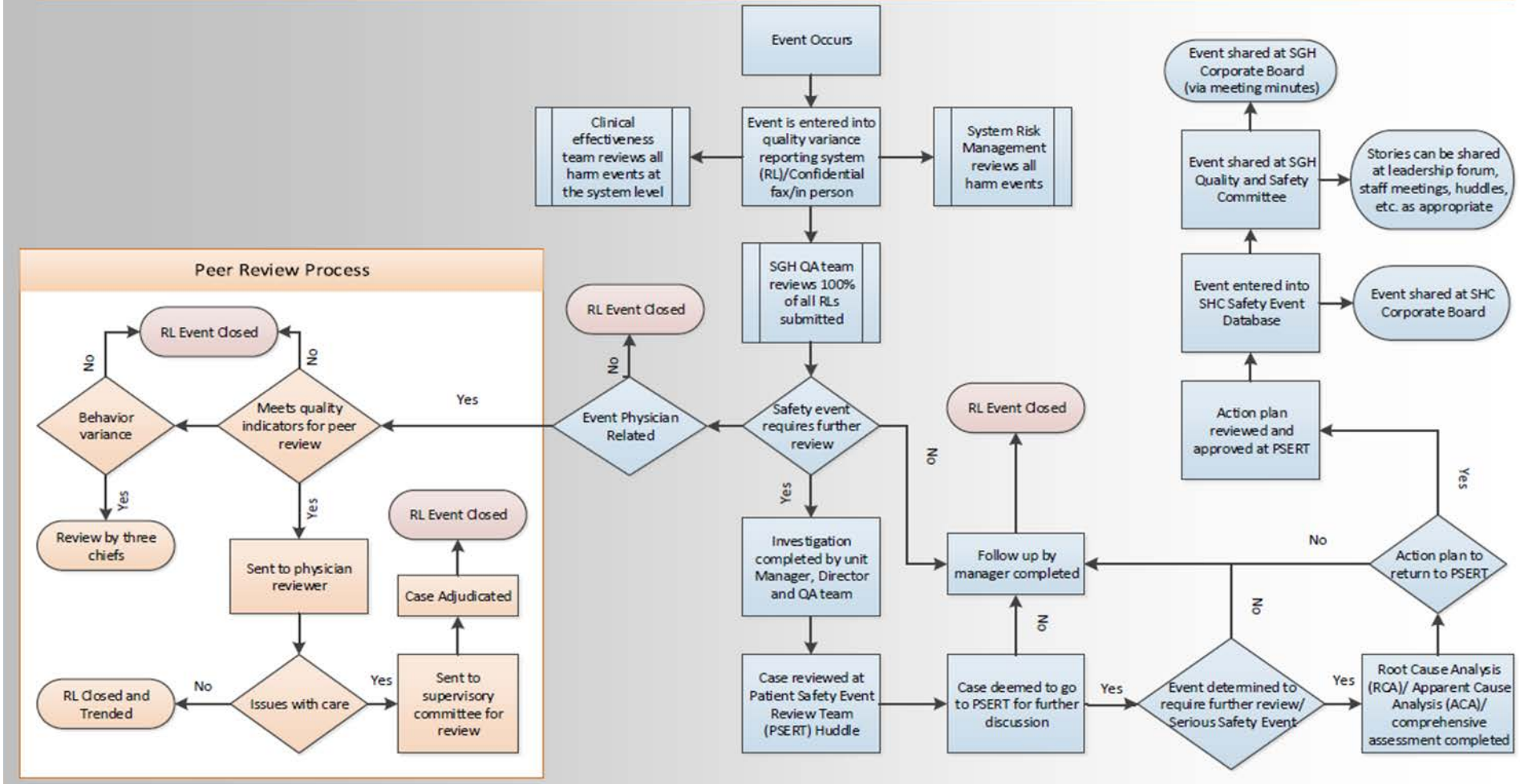
Deeper Dive

Spotlight on safety 2017

A brief interview with…

- Tametha Stroh, RN, MSN, CPPS, CPHRM
  - Director, Quality Improvement and Patient Safety

Safety Event Review Process



August 14, 2017

* Note: Near misses, precursor and serious safety events are subject to PSERT review and determination

Safety Events Defined

Sentinel Event/ Reportable Event/ "Never 29 Events" :

*These require reporting to California Department of Public Health (CDPH) or Center for Medicare and Medicaid Services (CMS).

- An adverse event or series of adverse events that cause the death or serious disability of a patient, a visitor, or personnel.
- "Serious disability" means a physical or mental impairment that substantially limits one or more of the major life activities of an individual, or the loss of bodily function, if the impairment or loss lasts more than seven days or is still present at the time of discharge from an inpatient health care facility, or the loss of a body part.

Healthcare Performance Improvement (HPI) :

- **Serious Safety Event (SSE)**: An event in which there was a deviation from generally accepted performance standards (GAPS) that reaches a patient and causes in a substantial way: death, severe permanent harm, moderate permanent harm, severe temporary harm, or moderate temporary harm
  - All Sentinel/ "Never 29" events fall into this category
- **Precursor Safety Event (PSE)**: An event in which there was a deviation from GAPS that reaches the patient and results in minimal harm or no detectable harm
- **Near Miss Safety Event (NME)**: A deviation from GAPS that does not reach the patient.

Safety Event Classification

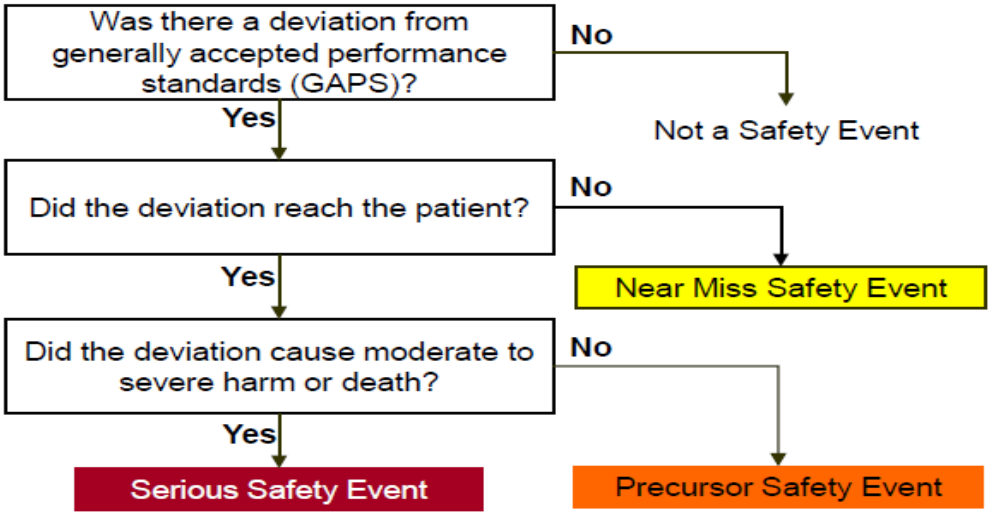


Figure 2. Safety Event Classification Algorithm

Best Practice Tips in Safety Event Classification

- ✓ Identify a consistent group of people to serve as a "Safety Event Review Panel" to provide expertise, consistency, and integrity in event classification. The group should be a mix of clinicians and methodology experts and senior enough to gain organizational trust.
- ✓ When classifying an event, use the SEC algorithm and always ask ALL the questions – e.g. *Was there a deviation? Did the deviation reach the patient? What was the level of harm?*
- ✓ Charge one person with the responsibility for thinking/asking about precedent.
- ✓ Keep a record of challenging event classification cases and classification rationale. This record provides a useful reference when assessing similar future cases and enables the group to look at changes in their own perspectives in event classification.
- ✓ What happens in the discussions, stays in the discussions. The group speaks with one voice outside the meetings.

The Known Complications Test

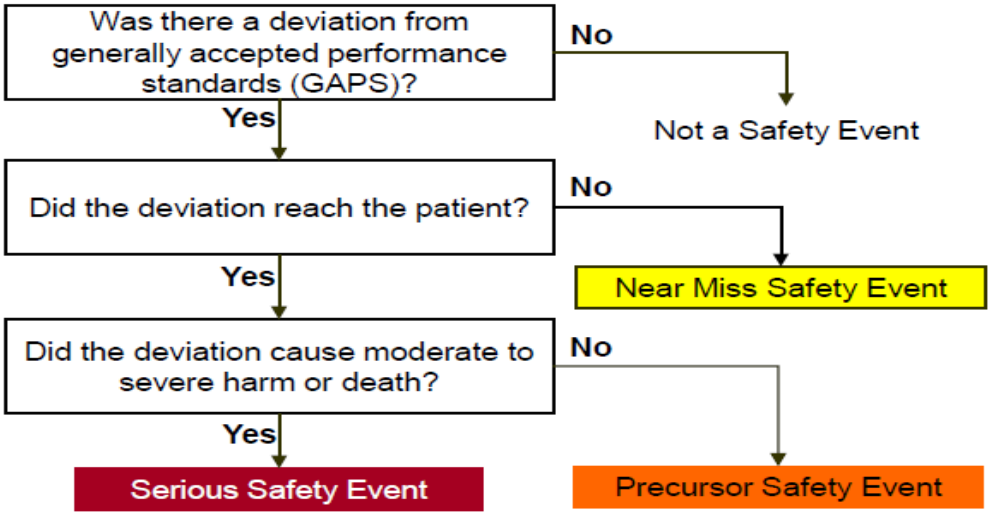
*A **known complication** is an adverse outcome supported in literature as a potential risk related to a procedure, treatment, or test that is not present before the patient care encounter and occurs as a result of patient care.*

If an event is perceived to be a known complication, the Known Complications Test can be used to confirm the event as a complication and to determine if providers did everything possible to prevent the negative outcome. If the patient experienced a "known complication," consider the following:

1. Was the procedure, treatment, or test appropriate and warranted based on nationally recognized standards of care?
2. Was the complication a known risk, was it anticipated before the procedure, and was the standard of care applied to mitigate the risk?
3. Was the complication identified in a timely manner (i.e. at the time of the occurrence)?
4. Was the complication treated according to the standard of care and in a timely manner?

If the answer to **all 4 questions** is **yes**, the event is considered a known complication and not a Safety Event. If the answer to **any question** is **no**, the event is a Safety Event. Proceed in defining the classification based on the level of harm to the patient.

Safety Event Classification



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Safety Event Classification Levels of Harm

	Code	Level of Harm	Description
Serious Safety Event	SSE 1	Death	A deviation in GAPS resulting in death
	SSE 2	Severe Permanent Harm	A deviation in GAPS resulting in critical, life-changing harm with no expected change in clinical status; includes events resulting in permanent loss of organ, limb, or vital physiologic or neurologic function **Example** – Wrong site procedure resulting in removal of healthy limb – Missed diagnosis of stroke resulting in permanent impairment – Uterine rupture resulting in loss of uterus – Anoxic brain injury resulting in permanent brain damage – Incorrect radiologic contrast dosing resulting in need for permanent dialysis
	SSE 3	Moderate Permanent Harm	A deviation in GAPS resulting in significant harm with no expected change in clinical condition yet not sufficiently severe to impact activities of daily living or business functioning; includes events that result in permanent reduction in physiologic reserve, disfigurement, and impaired or aided sense or function **Examples** – Incorrect radiology contrast dosing resulting in reduced renal function – Inadvertent injury to spleen during abdominal surgery requiring removal of the spleen – Delay in treatment of limb ischemia requiring fasciotomy that results in minimal loss of function but disfiguring scars – Inappropriate intra-arterial medication injection resulting in loss of a finger, other than the thumb or 2nd finger which may qualify the event as SSE 2
	SSE 4	Severe Temporary Harm	A deviation in GAPS resulting in critical, potentially life-threatening harm yet lasting for a limited time with no permanent residual; requires prolonged transfer to a higher level of care/monitoring, transfer to a higher level of care for a life-threatening condition, or an additional major surgery, procedure, or treatment to resolve the condition **Examples** – Induced condition that requires resuscitation – Unrecognized fluid overload that progresses to pulmonary edema requiring transfer to the ICU for treatment – Failure to diagnose respiratory insufficiency resulting in temporary intubation where earlier recognition of the condition would have avoided the intubation – Preventable fall with hip fracture that requires surgical repair – Retained object that requires return to the operating room
	SSE 5	Moderate Temporary Harm	A deviation in GAPS resulting in significant harm lasting for a limited time; requires a higher level of care/monitoring or an additional minor procedure or treatment to resolve the condition **Examples** – Failure to treat a low potassium level that results in an arrhythmia requiring administration of intravenous anti-arrythmic drug, but with continued arrhythmia requiring extended monitoring and a higher intensity of care – Incorrect dose of dilaudid for pain resulting in over-sedation and requiring transfer to ICU for treatment and monitoring after narcan was ineffective in treating – Failure to routinely assess IV site resulting in an infection at IV site or (septic phlebitis) requiring extensive surgical incision and drainage to resolve – Incision made on the right knee instead of the left knee during an schedule knee replacement surgery

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Safety Event Classification Levels of Harm

	Code	Level of Harm	Description
Precursor Safety Event	PSE 1	Minimal Permanent Harm	A deviation in GAPS resulting in minor harm with no expected change in clinical status; requires little or no intervention **Examples** – Inadequate protection of ulnar nerve during an operation resulting in numbness of 4th and 5th fingers – Excess radiation therapy resulting in skin color change in non-critical cosmetic area
	PSE 2	Minimal Temporary Harm	A deviation in GAPS resulting in minor harm lasting for a limited time only; requires little or no intervention **Examples** – Failure to assess IV site resulting in bruising or swelling – Retained sponge in vaginal cavity found and removed during office exam and resulting in no or minor infection – Administration of low dose insulin to a non-diabetic patient requiring only a glucose check and drink of orange juice – Incorrect dose of dilaudid for pain resulting in over-sedation and narcan resuscitation with immediate resolution – An anesthetic nerve block was performed on the right knee instead of the left knee in a scheduled knee replacement surgery before it was realized the wrong side had been anesthetized
	PSE 3	No Detectable Harm	A deviation in GAPS that reaches the patient yet without ability to determine the existence or fact of harm, yet harm may exist; includes events where the onset of harm may occur later in time **Example** – Procedure performed with un-sterile instruments with no detectable post-procedure complications or infection – Inappropriate technique resulting in losing coronary artery stent into systemic circulation with no evidence of limb or organ ischemia
	PSE 4	No Harm	A deviation in GAPS that reaches the patient yet results in no harm, with sufficient information available to determine that no harm occurred **Example** – Transfusion of blood intended for another patient yet of the correct blood type – Administration of an adult dose of vitamin K to a full term newborn infant with no resulting damage
Near Miss Event	NME 1	Unplanned Barrier Catch	A deviation in GAPS that passes through all error detection barriers and does not reach the patient because it is caught by chance or a barrier not designed into the system **Example** – Family member who reminds of a known medication allergy immediately before the medication is to be administered to the patient – Environment Services Associate points out the need to perform a time out prior to a bedside procedure resulting in awareness that the procedure was about to be performed on the incorrect limb – Food Services Associate notices pills in waste basket, thrown away by the patient, and alerts the patient's nurse who ensures medication administration
	NME 2	Last Strong Barrier Catch	A deviation in GAPS that passes through early error detection barriers and is caught by a last strong error detection barrier designed into the system **Example** – Medication error caught by nurse performing "5 Rights" prior to administration – Wrong patient brought to the OR and identified during the team time out
	NME 3	Early Barrier Catch	A deviation in GAPS that is caught by an early error detection barrier designed into the system's defense in depth **Example** – Medication error identified when a contraindication alert fires in the pharmacy order entry system – During bedside shift change report, care team identifies that multiple IV lines in a complex ICU patient are not labeled and makes the correction to minimize risk of confusion

Open Discussion

Adjournment of Joint Meeting

Grossmont Hospital Corporation Board Action Items

• Approval of Prior Month Minutes	Jerry Fazio
• Approval of Capital Request – DaVinci Xi Robot	Anthony D’Amico
• Approval of MEC Recommendations	Ali Banaie, MD
• Resolution 20_2017	
• Approval of CRED Committee Recommendations	Ali Banaie, MD
• Resolution 21_2017	

Adjournment of Joint Meeting