SAN GORGONIO
MEMORIAL HOSPITAL

AGENDA

REGULAR MEETING OF THE BOARD OF DIRECTORS
Tuesday, February 4, 2020 – 5:00 PM

Modular C Classroom
600 N. Highland Springs Avenue, Banning, CA 92220

In compliance with the Americans with Disabilities Act, if you need special assistance to participate in this meeting, please contact the Administration Office at (951) 769-2160. **Notification 48 hours prior to the meeting** will enable the Hospital to make reasonable arrangement to ensure accessibility to this meeting. [28 CFR 35.02-35.104 ADA Title II].

TAB

I. Call to Order — S. DiBiasi, Chair

II. Public Comment

A five-minute limitation shall apply to each member of the public who wishes to address the Hospital Board of Directors on any matter under the subject jurisdiction of the Board. A thirty-minute time limit is placed on this section. No member of the public shall be permitted to "share" his/her five minutes with any other member of the public. (Usually, any items received under this heading are referred to staff for future study, research, completion and/or future Board Action.) (PLEASE STATE YOUR NAME AND ADDRESS FOR THE RECORD.)

On behalf of the Hospital Board of Directors, we want you to know that the Board acknowledges the comments or concerns that you direct to this Board. While the Board may wish to occasionally respond immediately to questions or comments if appropriate, they often will instruct the Hospital CEO, or other Hospital Executive personnel, to do further research and report back to the Board prior to responding to any issues raised. If you have specific questions, you will receive a response either at the meeting or shortly thereafter. The Board wants to ensure that it is fully informed before responding, and so if your questions are not addressed during the meeting, this does not indicate a lack of interest on the Board's part; a response will be forthcoming.

OLD BUSINESS

III. ***Proposed Action - Approve Minutes** — S. DiBiasi
- January 7, 2020 regular meeting — A

NEW BUSINESS

IV. Healthcare District Board meeting report - informational — D. Tankersley — verbal

V.	Hospital Board Chair monthly report	S. DiBiasi	B
VI.	CEO monthly report	S. Barron	verbal
VII.	*** Proposed Action – Close Anesthesia Department** (limiting anesthesia privileges to contracted physicians only) ▪ **ROLL CALL**	S. Barron	verbal
VIII.	* Proposed Action – Approve Beaver Medical Group anesthesia agreement ▪ **ROLL CALL**	S. Barron	verbal/ handout
IX.	February, March & April Board/Committee meeting calendars	S. DiBiasi	C
X.	Bi-monthly Business Development/Information Technology report	H. Yonemoto	D
XI.	Foundation monthly report	V. Hunter	E
XII.	Annual completion of FPPC Statement of Economic Interest (Form 700) for 2019 (completed forms due back by March 13, 2020)	B. Duffy	handout
XIII.	*** Proposed Action – Approve:** • **2020 Performance/Process Improvement Prioritization Grid** • **2020 Performance Improvement Plan** • **2020 Patient Safety Plan** ▪ **ROLL CALL**	P. Brown for Pat Ziegler	F
XIV.	Committee Reports:		
	• Executive Committee o January 24, 2020 special meeting minutes	S. DiBiasi	G
	• Finance Committee o January 28, 2020 regular meeting minutes *** Proposed Action – Approve December 2019 Financial Statement** (approval recommended by Finance Committee 2/28/2020) ▪ **ROLL CALL**	O. Hershey D. Recupero	H
	*** Proposed Action Approve Line of Credit renewal** ▪ **ROLL CALL**		verbal/ handout
XV.	Chief of Staff Report *** Proposed Action - Approve Recommendations of the Medical Executive Committee** ▪ **ROLL CALL**	S. Hildebrand, MD Chief of Staff	I

XVI.	*** Proposed Action - Approve Policies and Procedures** ▪ **ROLL CALL**	Staff	J
XVII.	Community Benefit events/Announcements/ and newspaper articles	S. DiBiasi	K

***** ITEMS FOR DISCUSSION/APPROVAL IN CLOSED SESSION** S. DiBiasi

- Proposed Action - Approve Medical Staff Credentialing
  (Health & Safety Code §32155; and Evidence Code §1157)
- Receive Quarterly Emergency Preparedness/Environment Safety report
  (Health & Safety Code §32155)
- Receive Quarterly Corporate Compliance Committee report
  (Health & Safety Code §32155)
- Telephone conference with legal counsel regarding potential litigation
  Significant exposure to litigation pursuant to paragraph (2) or (3) of subdivision (d) of Section 54956.9: (one potential case)
- Receive Ad Hoc Affiliation Committee update (if any)
  (Health & Safety Code §32106 - Trade Secrets) Report containing information concerning proposed new service, program, or facility - information will become available when trade secret no longer exists)

XVIII. **ADJOURN TO CLOSED SESSION**

*** The Board will convene to the Open Session portion of the meeting approximately 2 minutes after the conclusion of Closed Session.**

RECONVENE TO OPEN SESSION

***** REPORT ON ACTIONS TAKEN DURING CLOSED SESSION** S. DiBiasi

XIX. Future Agenda Items

XX. **ADJOURN** S. DiBiasi

***Action Required**

In accordance with The Brown Act, *Section 54957.5*, all public records relating to an agenda item on this agenda are available for public inspection at the time the document is distributed to all, or a majority of all, members of the Board. Such records shall be available at the Hospital Administration office located at 600 N. Highland Springs Avenue, Banning, CA 92220 during regular business hours, Monday through Friday, 8:00 am - 4:30 pm.

San Gorgonio Memorial Hospital
Board of Directors Regular Meeting
February 4, 2020

Certification of Posting

I certify that on January 31, 2020, I posted a copy of the foregoing agenda near the regular meeting place of the Board of Directors of San Gorgonio Memorial Hospital, and on the San Gorgonio Memorial Hospital website, said time being at least 72 hours in advance of the regular meeting of the Board of Directors (*Government Code Section 54954.2*).

Executed at Banning, California, on January 31, 2020

Bobbi Duffy, Executive Assistant

TAB A

MINUTES: Not Yet Approved By Board

REGULAR MEETING OF THE
SAN GORGONIO MEMORIAL HOSPITAL
BOARD OF DIRECTORS

January 7, 2020

The regular meeting of the San Gorgonio Memorial Hospital Board of Directors was held on Tuesday, January 7, 2020 in Modular C meeting room, 600 N. Highland Springs Avenue, Banning, California.

Members Present: Lynn Baldi, Phillip Capobianco III, Steve Cooley, Susan DiBiasi (Chair), Andrew Gardner, Olivia Hershey, Estelle Lewis, Ehren Ngo, Ron Rader, Steve Rutledge, Georgia Sobiech, Lanny Swerdlow, Dennis Tankersley

Absent: None

Required Staff: Steve Barron (CEO), Pat Brown (CNO), Annah Karam (CHRO), Dave Recupero (CFO), Holly Yonemoto (CBDO), Steven Hildebrand, MD (Chief of Staff), Dan Mares (Director, Plant Operations), Bobbi Duffy (Executive Assistant)

AGENDA ITEM		ACTION / FOLLOW-UP
Call To Order	Chair Susan DiBiasi called the meeting to order at 5:01 pm.	
Public Comment	Kathy Conway, of Carol's Kitchen spoke to thank the Board for the Hospital staff assisting at their Christmas meal. Hospital staff helped with serving and anywhere they were needed. They also put together goodies bags for the adults, while the children saw Santa and received toys.	
OLD BUSINESS		
Proposed Action - Approve Minutes **December 3, 2019 regular meeting**	Chair DiBiasi asked for any changes or corrections to the minutes of the December 3, 2019 regular meeting as included on the board tablets. There were none.	**The minutes of the December 3, 2019 regular meeting will stand correct as presented.**
NEW BUSINESS		

AGENDA ITEM		ACTION / FOLLOW-UP
Healthcare District Board report - informational	Healthcare District Board Chair Dennis Tankersley, reported that a copy of the Healthcare District's meeting agenda and enclosures were included on the board tablets. He reviewed the actions taken at that meeting.	
Hospital Board Chair report	Chair DiBiasi noted that her written monthly report was included on the board tablets.	
CEO Monthly report	Steve Barron reported that the Hospital is doing well and has made money every month so far this year. He reported that YTD EBIDA is up $1.8 million compared to the previous year. He stated that the Emergency Department remained busy in December and that we are coming into the Hospital's busy season. Steve reported that we are still working on renewing the line of credit. He added that we anticipate receiving approximately $2 million from tax revenues from Riverside County. Steve reported that cash flow remains tight this time of year, mostly due to increased patient load which means higher salary and supply costs. Steve reminded all Board members of the Saturday, February 22nd Strategic Planning session.	
Calendars	Calendars for January, February, and March were included on the board tablets and "take home" copies were at each board member's seat.	
Patient Care Services bi-monthly report	Pat Brown, CNO, reviewed her written report that was placed at each board member and staff's seats.	
All Hospital Board members annual execution of Confidentiality and Nondisclosure Agreement	Chair DiBiasi noted that the Confidentiality and Nondisclosure Agreement is presented annually for each board member's signature. These were placed at each board member's seat. Board members should sign and turn it in to Bobbi Duffy prior to leaving tonight's meetings.	
Proposed Action	Chair DiBiasi noted that the bylaws require that the Board	**M.S.C.,**

<table>
<tr><th>AGENDA ITEM</th><th></th><th>ACTION / FOLLOW-UP</th></tr>
<tr><td>– Annual Approval of Hospital Bylaws</td><td>review and approve their bylaws annually. She asked if there were any suggested changes to the current Healthcare District bylaws. It was noted that staff had no recommended changes.

BOARD MEMBER ROLL CALL:

<table>
<tr><td>Baldi</td><td>Yes</td><td>Capobianco</td><td>Yes</td></tr>
<tr><td>Cooley</td><td>Yes</td><td>DiBiasi</td><td>Yes</td></tr>
<tr><td>Gardner</td><td>Yes</td><td>Hershey</td><td>Yes</td></tr>
<tr><td>Lewis</td><td>Yes</td><td>Ngo</td><td>Yes</td></tr>
<tr><td>Rader</td><td>Yes</td><td>Rutledge</td><td>Yes</td></tr>
<tr><td>Sobiech</td><td>Yes</td><td>Swerdlow</td><td>Yes</td></tr>
<tr><td>Tankersley</td><td>Yes</td><td colspan="2">Motion carried.</td></tr>
</table></td><td>(Sobiech/ Rader), the SGMH Board of Directors approved their bylaws as presented.</td></tr>
<tr><td>Proposed Action – Approve 2020 Environment of Care Plans</td><td>Dan Mares briefly reviewed the 2020 Environment of Care Plans as included on the board tablets. These plans included:
2020 Hazardous Materials and Waste Management Plan
2020 Life Safety (Fire Safety) Plan
2020 Utilities Management Plan
2020 Medical Equipment Management Plan
2020 Environmental Safety and Security Management Plan
2020 Emergency Management Plan
BOARD MEMBER ROLL CALL:

<table>
<tr><td>Baldi</td><td>Yes</td><td>Capobianco</td><td>Yes</td></tr>
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<tr><td>Sobiech</td><td>Yes</td><td>Swerdlow</td><td>Yes</td></tr>
<tr><td>Tankersley</td><td>Yes</td><td colspan="2">Motion carried.</td></tr>
</table></td><td>M.S.C., (Rader/ Rutledge), the SGMH Board of Directors approved the 2020 Environment of Care Plans as presented.</td></tr>
<tr><td colspan="3">COMMITTEE REPORTS:</td></tr>
<tr><td>Ad Hoc Audit Selection</td><td>Chair DiBiasi reported RFP requests for a new audit firm went out in December with a January 20th deadline to have</td><td></td></tr>
</table>

<table>
<tr><th>AGENDA ITEM</th><th></th><th>ACTION / FOLLOW-UP</th></tr>
<tr><td>Committee</td><td>proposals in. She thanked Andrew Gardner for his efforts in getting good information on who to speak with at the various organizations. She reported that the Committee hopes to bring a recommendation for a new audit firm to the March Board meeting for the Board's approval.</td><td></td></tr>
<tr><td>Executive Committee</td><td>Chair DiBiasi reported that a copy of the minutes of the December 17, 2019 were included on the board tablet. At that meeting they approved the Community Health Needs Assessment which is now posted on the Hospital's website as required by laws.</td><td></td></tr>
<tr><td>Finance Committee

Proposed Action – Approve November 2019 Financial Statement</td><td>At the request of Committee Chair Olivia Hershey, Dave Recupero, Chief Financial Officer, briefly reviewed a handout Executive Summary along with the November 2019 Financial report which was included on the board tablet. A copy of the Finance Committee's December 19, 2019 meeting minutes were also included on the board tablet. It was noted that the Finance Committee recommends approval of the November 2019 Financial report as presented.

BOARD MEMBER ROLL CALL:

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<tr><td>Sobiech</td><td>Yes</td><td>Swerdlow</td><td>Yes</td></tr>
<tr><td>Tankersley</td><td>Yes</td><td colspan="2">Motion carried.</td></tr>
</table></td><td>M.S.C., (Hershey/ Ngo), the SGMH Board of Directors approved the November 2019 Financial report as presented.</td></tr>
<tr><td>Proposed Action – Approve Policies and Procedures</td><td>There were four (4) policies and procedures included on the board tablets presented for approval by the Board.

BOARD MEMBER ROLL CALL:

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<tr><td>Baldi</td><td>Yes</td><td>Capobianco</td><td>Yes</td></tr>
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<tr><td>Rader</td><td>Yes</td><td>Rutledge</td><td>Yes</td></tr>
<tr><td>Sobiech</td><td>Yes</td><td>Swerdlow</td><td>Yes</td></tr>
</table></td><td>M.S.C., (Swerdlow/ Baldi), the SGMH Board of Directors approved the policies and procedures as submitted.</td></tr>
</table>

AGENDA ITEM		ACTION / FOLLOW-UP
	Tankersley | Yes | Motion carried.	
Community Benefit events/Announcements/and newspaper articles	Miscellaneous information was included on the board tablets and handouts were at seats. Chair DiBiasi thanked the Medical Staff for the invitation to attend their annual holiday party. A number of Board members attended and had a good time. Lynn Baldi reminded everyone that Steve Barron will be the featured speaker at the Beaumont Chamber's Good Morning Beaumont breakfast on Friday, January 10th at 7:30 am at Tukwet Canyon. Lynn Baldi also noted that the Beaumont Chamber's Annual Installation dinner will be held January 30th. At this event, they will install their new officers and honor Jim and Linda Anderson of Cherry Valley Nursery at their Citizens of the Year.	
Adjourn to Closed Session	Chair DiBiasi reported the items to be reviewed and discussed and/or acted upon during Closed Session will be: ➢ Proposed Action - Approve Medical Staff Credentialing ➢ Receive Quarterly Environment of Care/Life Safety/Utility Management report ➢ Receive 2019 Annual Environment of Care evaluations ➢ Telephone conference with legal counsel regarding potential litigation (1 potential case) The meeting adjourned to Closed Session at 5:56 pm. The public, and staff members Dave Recupero, Annah Karam, and Holly Yonemoto left the meeting prior to the closed session.	
Reconvene to Open Session	The meeting reconvened to Open Session at 6:49 pm. No public was waiting to return to the meeting At the request of Chair DiBiasi, Bobbi Duffy, Executive Assistant, reported on the actions taken/information received	

AGENDA ITEM		ACTION / FOLLOW-UP
	during the Closed Session as follows: ➢ Approved Medical Staff Credentialing ➢ Received Quarterly Environment of Care/Life Safety/Utility Management report ➢ Received 2019 Annual Environment of Care evaluations ➢ Participated in a telephone conference with legal counsel regarding potential litigation (1 potential case)	
Future Agenda Items	None	
Adjourn	The meeting was adjourned at 6:51 pm.	

In accordance with The Brown Act, *Section 54957.5*, all reports and handouts discussed during this Open Session meeting are public records and are available for public inspection. These reports and/or handouts are available for review at the Hospital Administration office located at 600 N. Highland Springs Avenue, Banning, CA 92220 during regular business hours, Monday through Friday, 8:00 am - 4:30 pm.

Respectfully submitted by Bobbi Duffy, Executive Assistant

TAB B

SAN GORGONIO
MEMORIAL HOSPITAL

Report from Chair Susan DiBiasi
February 4, 2020

During the month of January:

- Attended and reviewed future state Flowchart reviews of various components of Sunrise Community Care with departments and key users participating
- Conducted Executive Committee meeting – included in another report
- Attended Finance Committee
- Met with CEO Steve Barron for planning and updates

TAB C

February 2020

SAN GORGONIO MEMORIAL HOSPITAL

Board of Directors Calendar

Sun	Mon	Tue	Wed	Thu	Fri	Sat
						1
2	3	4 **4:00 pm Healthcare Dist. Board mtg.** **5:00 pm Hospital Board mtg.**	5	6 3:00 pm—Cafeteria General Staff mtg and Associate of the Month	7	8
9	10	11	12	13	14	15
16	17 **President's Day** Administration Closed	18	19 **9:00 am HR Comm. mtg.**	20	21	22 **Hospital Board Strategic Planning Session—Location and time TBD**
23	24	25 **9:00 am Finance Committee mtg.**	26	27	28	29

As of January 28, 2020 Items in **bold** = Board/Committee meetings Items with * = Associate functions that Board members are invited to attend

March 2020

SAN GORGONIO MEMORIAL HOSPITAL

Board of Directors Calendar

Sun	Mon	Tue	Wed	Thu	Fri	Sat
1	2	3 **4:00 pm Healthcare District Board mtg.** **5:00 pm Hospital Board mtg.**	4	5 3:00 pm—Cafeteria General Staff mtg and Associate of the Month	6	7
8 	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31 **9:00 am Finance Committee mtg.** **10:00 am Executive Committee mtg.**				

As of January 28, 2020

Items in **bold** = Board/Committee meetings

Items with * = Associate functions that Board members are invited to attend

April 2020

SAN GORGONIO MEMORIAL HOSPITAL

Board of Directors Calendar

Sun	Mon	Tue	Wed	Thu	Fri	Sat
			1	2	3	4
5	6	7 **4:00 pm Healthcare District Board mtg.** **5:00 pm Hospital Board mtg.**	8	9 3:00 pm—Cafeteria General Staff mtg and Associate of the Month	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28 **9:00 am Finance Committee mtg.**	29	30		

As of January 28, 2020 Items in **bold** = Board/Committee meetings Items with * = Associate functions that Board members are invited to attend

TAB D

San Gorgonio Memorial Hospital Board Report
Business Development & Information Technology Report
Holly Yonemoto, CBDO & CIO
February 2020

INFORMATION TECHNOLOGY

ALLSCRIPTS/SUNCOM UPDATE
Allscripts came on site the week of January 20th and had scheduled sessions during the week for our EHR structure and workflow review. There was a lot of good information exchanged and the review with the directors and selected users was very helpful for both Allscripts and the SGMH team. We continue to move forward with the necessary tasks and have many more to complete but we should be completely on schedule in two weeks – 2 departments final task completion.

REORGANIZATION/RESOURCES
In working on the infrastructure changes needed for the preparation for our new Allscripts EHR a need for a higher level of technical knowledge and leadership became apparent. We have contracted with Accent Computer Solutions to provide recommendations for our IT infrastructure as well as cyber-security. Additionally, Accent Computer Solutions will provide monthly monitoring and maintenance on all applications which includes updates as well as ongoing technical infrastructure support. The reorganization resulted in 2 individuals accepting other positions available and the leadership of the department will be filled by Holly Yonemoto, Chief Information Officer.

BUSINESS DEVELOPMENT

ORTHOPEDIC SURGERY
On Business Development activity, we have had many initiatives in the pipeline to increase our community healthcare capture rate and a significant milestone that we have been working towards for months has come to fruition. We have been working for months on the contracting and credentialing of additional orthopedic surgeons. Two have already started with monthly surgery days and the latest surgeons were credentialed recently and will be covering the emergency department orthopedic call, in addition to the call coverage provided by Dr. Reis. In February, the orthopedic coverage with Dr. Reis and Arrowhead Orthopedic physicians will provide the community the assurance that their orthopedic needs will be addressed 24/7 in our emergency department and potentially increase surgical cases and increase ED volume. The coverage will be a great service to the community having additional high-quality, highly-respected orthopedic surgeon coverage.

TELE-NEUROLOGY

We are close to the completion of the contracting and operational/technical preparation for tele-neurology coverage for Stroke and other neurology assessment needs. There is currently daily communications with the neurology group and 3 out of 4 neurologists are in the credentialing process. We are in discussions on how soon we can start so looking forward to great news soon.

IMAGING CENTER - EDA GRANT

We met on January 27th with the EDA representatives for grant funding with a 50% match for an Imaging Center. The imaging center would essentially have all new equipment/ replacement of all current imaging modalities as well as a remodel and construction for a building to house the MRI physically close to the hospital. The grant submission is requested to be April 1 with further details of equipment cost, construction estimates and construction timelines to be submitted. Much work needed for the EDA grant submission and very high potential for funding.

TAB E

SAN GORGONIO
MEMORIAL HOSPITAL
FOUNDATION

February 4, 2020

Foundation Finances –

- **Bank of Hemet:**
  - $285,546.43 (business checking account) as of 01/21/2020
  - $127,469.76 (money market account) as of 01/21/2020
- **Community Foundation:** $318,662.51 as of 01/21/2020
- **Total Funds:** $731,678.70

Foundation News –

- As of January 1, 2020 the new SGMH Foundation president is George Moyer.

- January started off great with the cafeteria and the gift show now collecting donations in partnership with the foundation.

- Saturday March 14, 2020 is the Annual Dinner Gala at Morongo Casino Resort & Spa. The vision for the event is a Tribute to our veterans. The tribute is to bring to light the cornerstone of SGMH being founded as a memorial to World War I & World War II veterans. The Vision for the gala with a tribute to veterans brings the reason for SGMH full-circle. Also there will be an announcement at the Gala that in 2023 SGMH will have its own Veterans memorial. Valerie is hoping to create the memorial in partnership with Pardee Development – across the street.
  If you or anyone you know would like a veteran or active military acknowledged at the Gala, please let Valerie know. Any size contribution will get your loved ones name acknowledged.

- Valerie is doing extensive database training to ensure that the software that is currently in place in the Foundation office is used properly. Issues with how the data was being house previously was unearthed however, there is way to do a global updates in order to keep information current and searchable so that future fundraising efforts will be successful. This effort will take a lot of work but she is hoping it can be done within a year's time.

- Valerie is also working with a Global Grant services to write current Grants to funders who have already given to SGMHF in the past. Funders such as: Wells Fargo Foundation, The Weingart Foundation, the California Endowment, Ralph & Food for Less Foundation, The Wallis Foundation and the Deutsch Foundation.

Community Outreach –

- The Foundation will host a Joint-Chamber mixer with Banning, Beaumont, Calimesa, Yucaipa to introduce George Moyer as the new SGMH Foundation President and Valerie Hunter as the new Foundation Director.
    - The mixer will also reflect on equipment that the foundation has purchased for the hospital with talking-points given by Mgr. and/or Directors of the departments that have received the equipment.

TAB F

SAN GORGONIO MEMORIAL HOSPITAL
2020 Performance/Process Improvement Project Prioritization Grid

Approved by Executive Team: _____ **Date:** 1/20/2020

Approved by Medical Executive Committee: _____ MD **Date:** 1/15/2020

Approved by Governing Board: _____ **Date:** _____

Proposed Project	Reason for Inclusion Check all that Apply						Significance of Issue			Severity of Issue			Prevalence of Issue			Total Points	Ranking	Outcome Check One			
	Low Volume = 1pt	High Risk = 1pt	Problem Prone = 1pt	Improved Outcomes = 1pt	Patient Safety = 1pt	Quality of Care = 1pt	Low Significance = 1pt	Moderate Significance = 2pt	High Significance = 3pt	Low Severity = 1pt	Moderate Severity = 2pt	High Severity = 3pt.	Isolated & Localized = 1pt	Multiple Areas = 2pt	Organization-Wide = 3pt	Enter Total Number of Points	Highest to Lowest Point Total	Project Approved	Project Tabled	Project Not Approved	Other
HEART Program Team Response to Adverse Events Organization-wide (BETA)		X	X	X	X	X			X			X			X	14	#1				
Management of Sepsis - Multidisciplinary Team (Patient Safety & Problem-Prone) Continued from 2019	X	X	X	X	X	X			X			X		X		14	#1				
Patient Experience Multidisciplinary Committee Continued from 2019		X	X	X	X	X			X			X			X	14	#1				
Patient & Family Engagement Process Multidisciplinary Team (CMS Regulation/Patient Safety)		X	X	X	X	X			X			X			X	14	#1				
Antibiotic Stewardship – Appropriate Antibiotic Use Team - Ongoing Inpatient & Outpatient	X	X	X	X	X	X			X			X		X		14	#1				
Homeless Patient Discharge Process (State Law) Continued from 2019	X	X	X	X	X	X			X				X	X		14	#1				
Bridge Program (Management of Opioid Use)	X	X	X	X	X	X			X			X		X		14	#1				
Data Transparency Team (Community Engagement) Hospital Quality Institute	X		X					X						X		6	#2				

Origination:	*03/2013*
Approved:	*N/A*
Last Revised:	*01/2020*
Policy Area:	*Performance Improvement*
References:	

2020 Performance Improvement Plan

DEFINITION:

Performance or Quality Improvement is a collaborative approach to the continuous study and improvement of the processes of providing health care services to meet the needs of consumers and others. The improvement process depends on understanding and revising processes on the basis of data, use of statistical tools for data analysis, and knowledge about the processes themselves. Performance/Quality Improvement activities involve:

- Identifying issues and establishing priorities
- Developing measures of safety, quality and performance
- Collecting data to evaluate status on outcomes, processes, or structures
- Prioritizing improvement activities based on a measurement scale
- Analyzing and interpreting data
- Making and Implementing recommendations and actions for improvement
- Assessing the effectiveness of the actions taken
- Monitoring and sustaining performance improvement

PURPOSE:

To establish and sustain an organization-wide planned, systematic, and interdisciplinary approach to improving the quality and safety of inpatient and outpatient care and services provided to the population served. The Performance Improvement Program focuses on maintaining and improving the quality and safety of important processes, systems, services and functions at San Gorgonio Memorial Hospital (SGMH). The objective is to deliver safe, cost-effective, appropriate and medically necessary quality health care and related services with competence, trust and sensitivity to our patients, physicians, and the community by the provision of patient services designed to achieve the intended outcome of the patient's treatment plan and ensure patient safety.

The fundamental principles of performance improvement are collecting data, analyzing the data, and taking actions to improve. Ongoing performance measurement includes the assessment of the key systems, processes and functions within the organization to ensure that they are designed, or redesigned, to support a culture of quality and safety. The leaders create and maintain a culture of safety and quality throughout the organization and use hospital-wide planning to establish structures and processes that focus on safety & quality. SGMH is dedicated to providing the resources and training to the staff and empowers the employees to continuously improve programs and services**.** The Administrative, Medical Staff and Hospital Board Leaders of SGMH determine performance improvement priorities annually and approve the design of the methods used

to measure and improve organization-wide performance and outcomes.

The entire organization is committed to assessing, improving and maintaining safe, high-quality, cost-effective ~~healthcare~~health care services to our patients in compliance with all applicable laws, regulations and standards. The Performance Improvement Program supports the Mission, Vision and Core Values of the hospital.

AUTHORITY AND RESPONSIBILITY:

Leaders:

The organization's leaders have ultimate responsibility for performance improvement. They set performance improvement priorities and provide the resources needed to achieve improvement. The leaders make sure that all individuals who work in the organization participate in performance improvement activities.

Board of Directors:

The SGMH Board of Directors is ultimately responsible for the safety and quality of care provided by the medical and hospital staff members. The Board reviews and approves the Performance Improvement and Patient Safety Plans and the Performance/Process Improvement Project Prioritization Grid on an annual basis.

The Board participates in the identification of priorities for improvement using the mission, vision, and values of the organization, strategic planning goals, the review of performance improvement reports and data provided by the performance improvement staff, industry and community standards and trends, regulatory agency standards, guidelines, rules & regulations, and other available resources as a basis for decision-making.

Medical Executive Committee/Quality Council:

The Board of Directors delegates the development, implementation, monitoring and evaluation of the Performance Improvement Plan to the SGMH Medical Executive Committee (MEC). The MEC is responsible for improving the quality and safety of clinical care and service provided by the hospital staff and its medical staff. The MEC utilizes the "Quality Council" to carry out part of this function. The Quality Council is a multi-disciplinary committee comprised of representatives of the governing board, medical staff, administration, performance improvement, risk management, and selected hospital directors as invited.

Administration and Management:

The Board also delegates the development, implementation, monitoring and evaluation of the P.I. Plan to the SGMH Administration and Management Team. The administration and management team are responsible for providing the time and financial resources needed to improve the operational quality of care, safety culture and services provided by SGMH and its staff.

Patient Safety/Performance Improvement Committee:

This hospital committee focuses on organization-wide patient safety and performance improvement monitoring and review activities including, but not limited to, department-specific performance and outcome measures designed to identify opportunities for improvement, patient satisfaction reports, multidisciplinary P.I. Team/ Task Force projects, staff perceptions of patient safety and error reporting, Core Measures Reports, Patient Safety Organization quality measures reports, Regulatory agency deficiencies & related action plans for correction, Compliance reports, adverse events, and gap analysis activities, failure mode effects analysis and root cause analysis assessments, EOC/hazardous surveillance reports, Provider-preventable conditions reports, etc. A Quarterly Summary report of the above activities is presented at the Medical Staff Quality Council, the Medical Executive Committee and the Governing Board meetings.

DESIGNING PROCESSES AND SERVICES:

When designing a new or modified process or service, SGMH will strive to assure that it is designed well. The following criteria are utilized to determine the effectiveness of design:

- The design is consistent with the Mission, Vision, Values and organizational objectives of SGMH.
- The design meets the needs of the individuals served, organization and medical staff, and key stakeholders.
- When clinical processes are involved, the design is sound and consistent with acceptable national and/or community standards of care.
- The design is consistent with sound business practice, and reflects stewardship of resources.
- The design, as appropriate, incorporates information about new technology and/or the performance of similar design(s) in other organizations.
- The design, as appropriate, incorporates information from other organizations about "failure modes" and the "occurrence of adverse events".
- The design incorporates the results of performance improvement activities.

ESTABLISHING PERFORMANCE MEASURES:

SGMH will establish measurements to monitor its performance and patient care outcomes. The scope of measurement will take into consideration, and be consistent with, the important care and services provided, and the critical functions of the organization.

Criteria:

The following criteria is used to determine the scope and prioritization of performance measurement and improvement:

- Assure the safety of the environment of care
- Assure the safety of the providers of care and the recipients of care
- Further the Mission and strategic objectives of SGMH
- Meet legal, regulatory, ~~licensure~~license and accreditation requirements
- Establish the effectiveness, timeliness, and stability of processes that are high-risk, high-volume or problem-prone
- Establish desirable outcomes of care for at-risk populations
- Determine the effectiveness of the design of new or modified services.

Scope of Performance Measurement:

Based on the application of the above criteria, the following care, services, and functions are monitored and/or measured:

- HEART Program Team Response to Adverse Events
- Bridge Program Management of Opioid Use
- Patient/Family Engagement Process
  ~~ED Throughput & Patient Safety~~
- **Patient Experience Multidisciplinary Committee**
- **Data Transparency (HQI Community Engagement)**
- Management of Sepsis Bundle
- C-Difficile Infection Monitoring
- Homeless Patient Discharge ~~Proces~~Process

- EMTALA Review
- Medical Screening Exams (OB & ED)
- Safety & Appropriateness of Tubing Connectors
- Risk Management/Error Prevention activities
- Utilization Review/Case Management/Discharge Planning & Social Services
- Core Measures
- Medication Error Reduction Program (MERP)
- Antibiotic Stewardship Program (Inpatient & Outpatient)
- Patient/Family Engagement Activities
- Organization-wide Culture of Safety
- Leadership Effectiveness in Establishing a Culture of Safety
- Quality Control Activities
- Staff Opinions and Education Needs
- Outcomes of Selected Processes or Services
- Autopsy Results
- BETA Healthcare Services
- Customer Satisfaction
- Control & Prevention of Infection
- Survey on Perceptions of Patient Safety & Reporting Errors in Healthcare
- Use of Medications
- Performance of Operative, Invasive and Non-Invasive Procedures that Place Patients at Risk (Inpatient & Outpatient)
- Use of Blood and Blood Components
- Use of Restraints
- Care and Service to High-Risk Populations
- Outcomes related to "Rapid Response Team" interventions and Cardio-Respiratory Resuscitation (Code Committee)
- Outcomes Related to the Use of Procedural Sedation
- Adverse Events/Significant Near Misses
- Patient Complaints/Grievance Process
- Federal & State Required Improvement Projects
- Hospital Improvement Collaboratives (CAL-HIIN, PRIME, HEART, TeamSTEPPS, etc.)
- Medi-Cal Provider Preventable Conditions
- Value-Based Purchasing Program
- Continuous Survey Readiness

Measurement of the above areas may be organization-wide in scope, targeted to specific areas, departments and services, or focused on selected populations. Measurement may also be ongoing, time-limiting, episodic, intensive, or recurring. The duration, intensity, and frequency of a particular performance measure are based on the needs of the organization, external requirements, and the result of data analysis.

Data Collection and Aggregation:

Collecting data is the foundation of performance improvement. You can't improve unless you've measured first (baseline).

Purpose:

The purpose of data collection is to:

- Establish a baseline level of performance
- Determine the stability of the process
- Determine the effectiveness of a process or desirability of an outcome as compared to internal or external targets (benchmarks)
- Identify opportunities for improvement
- Identify the need for more focused data collection
- Determine whether improvement has been achieved and/or sustained.

Structure:

Performance measures require structure to assure that data is appropriately identified, collected, aggregated, displayed, and analyzed. In general, this structure should consist of:

- A definition of the measure – including the dimensions of performance being measured
- The population to be measured (including, when appropriate, criteria for inclusion and/or exclusion
- The type of measurement (i.e. rate based or event based)
- The minimum sampling size to assure statistical validity
- The frequency of data collection/aggregation
- The methodology by which data will be collected
- The entity/individual(s) primarily responsible for data collection
- The manner in which aggregated data will be displayed
- The entity(s) to which the aggregated data will be reported to for analysis and action.

Assessment of Performance:

Data on performance measures will be analyzed to identify "opportunities for improvement". There are two (2) basic approaches utilized by SGMH to assess performance and/or outcomes:

Assessment of Aggregated Data:

Data on "rate based" performance measures are aggregated to determine patterns, trends, and variation (common or special cause). Data may be aggregated for a single point in time or over time, depending on the needs of the organization and the reason for monitoring the performance or outcome. In general, measurement designed to establish the desired stability of a process or desired outcome will be measured over time until target levels of performance are met. Once a process is considered stable, and/or a desired level of performance has been achieved, then an assessment of performance measures may be conducted in a more episodic fashion.

Data that is "event-based" is assessed in singular or aggregated form depending on the number of data elements in the performance measure. In general, event-based measurements are monitored on an ongoing basis.

Intensive Assessments:

Data will be intensively assessed when SGMH detects or suspects a significant undesirable performance or variation. Intense analysis is called for when:

- Levels of performance, patterns, or trends vary significantly and undesirably from those expected.
- Performance varies significantly and undesirably from that of other organizations or recognized standards.
- An adverse event has occurred.
- There is a confirmed hemolytic transfusion reaction.
- There is a significant medication error.

- There is a significant adverse drug reaction.
- There is a major discrepancy or pattern of discrepancy between preoperative and postoperative diagnosis – including those identified during pathologic review of specimens removed during surgical or invasive procedures.
- There is a significant adverse event associated with anesthesia.

IMPROVING PERFORMANCE:

Performance Improvement Model:

SGMH will undertake efforts to improve existing processes and outcomes, and then sustain the improved performance. The accomplish this, SGMH has adopted a performance improvement model – PDCA. This model is explained below:
P = **Plan** to Implement Action
D = **Do** Implement the Plan
C = **Check** the Results
A = **Act** on the Findings

"Rapid-Cycle PDCA" is utilized when there is a need for rapid action and improvement on a high-risk issue or concern. These performance improvement models are utilized – formally or informally – in improvement efforts throughout the organization.

Sustaining Performance:

SGMH also recognizes that in order for performance improvement to be sustained, key staff must be educated about redesign of processes or other changes that are being implemented. To that end, the following processes have been established:

- The results of performance and improvement activities are communicated, as appropriate, to the Medical Staff and hospital staff through their respective organizational structures.
- The Board of Directors receives regular reports on the organization's performance and improvement activities.
- The input of key staff is sought to identify problem-prone areas and opportunities for improvement.

Annual Evaluation:

On an annual basis, this plan will be evaluated to determine if any changes to the scope or content must be made. The SGMH Performance Improvement Director will facilitate this review. Any changes or recommendations will be forwarded to the Patient Safety/Performance Improvement Committee, the ~~Quality Council, the~~ Medical Executive Committee and the Board of Directors for review and approval.

Attachments:

Approval Signatures

Step Description	Approver	Date
Hospital Board of Directors	Bobbi Duffy: Executive Assistant	pending
Medical Executive Committee	Amelia Frazier: Director Medical Staff Services	01/2020
Performance Improvement Committee	Pat Ziegler: Director Performance Improvement	01/2020

Step Description	Approver	Date
Policy & Procedure Committee	Gayle Freude: Nursing Director Med/Surg	01/2020
	Pat Ziegler: Director Performance Improvement	01/2020

Origination:	*03/2013*
Approved:	*N/A*
Last Revised:	*01/2020*
Policy Area:	*Performance Improvement*
References:	

2020 Patient Safety Program

Purpose:

The safety and quality of care, treatment, and services depend on many factors including the following:

- An organization-wide culture that fosters safety as a priority for everyone who works in the hospital
- The planning and provision of services that meet the needs of patients
- The availability of resources – human, financial, and physical – for providing care
- The existence of competent staff and other care providers
- Ongoing evaluation of, and improvement in, performance

The Patient Safety Program is designed to support and promote the mission, vision and values of San Gorgonio Memorial Hospital. The organization–wide patient safety program is committed to promoting the safety of all patients, visitors, volunteers, physicians, healthcare workers, and students. The program is designed to reduce medical/health system errors and hazardous conditions by utilizing continuous improvement to support an organizational safety culture. A safe and just culture is promoted and supported by the organization's leadership. This plan has been implemented through the integration and coordination of the patient safety activities of multiple safety organizations, teams, task forces, committees, departments, and patient care/patient support services with responsibility for various aspects of patient and employee safety, including but not limited to:

- HEART Program Team Response to Adverse Events
- Bridge Program Management of Opioid Use
- Patient/Family Engagement Process
  ~~ED Throughput & Patient Safety~~
- Patient Experience Multidisciplinary Committee
- Data Transparency (HQI Community Engagement)
- Homeless Patient Discharge Process
- Management of Sepsis Bundle
- C-Difficle Infections Monitoring
- Periodic Survey on "Leadership Effectiveness in Establishing a Culture of Safety"
- Hospital-wide Associate Survey on Culture of Safety and Error Reporting (q 2 years)
- Security/Safety Risk Assessments
- Corporate Compliance/HIPAA
- Medical Screening Exams (in OB and ED)
- EMTALA Regulations
- Employee Health Services/Workers Compensation

- EOC/Safety Committee - Life Safety/Emergency Preparedness/Hazard Vulnerability Assessments/ Statement of Conditions, Pro-Active Environmental Safety Rounds & Corrective Action Plans and EOC Plans
- Infection Prevention and Control
- Adverse Events and Significant Near Miss Events (Root Cause Analysis and Corrective Action)
- Adverse Event Alerts Gap Analysis Improvement Process including managing risk of tubing ~~misconnection~~mis-connection during the transition to new ISO tubing connector standards.
- Improve "Hand-Off Communication" throughout the organization (Safety Survey Issue)
- Laboratory/Diagnostic Imaging Quality Control
- Materials Management/Equipment Preventive Maintenance Program
- Monitoring for the Occurrence of "Clinical and Environmental Never Events"
- Department-specific Patient Care Services Performance & Outcome Measures
- Core Measures and Meaningful Use Regulatory Compliance
- Patient Complaint & Grievance Process
- Organization-wide Performance Improvement Monitoring Activities
- Pharmacy/Medication Error Reduction Plan (MERP)/ADR & Medication Error Reporting
- Antibiotic Stewardship Program (Inpatient & Outpatient)
- Local, State & Federal Improvement Measures/Projects (i.e. CAL-HIIN, HEART and PRIME Programs)
- Medi-Cal Provider Preventable Conditions
- Continuous Survey Readiness

Scope & Applicability:

The Patient Safety Program is organization-wide in scope and applicability. Therefore, it is applicable to all inpatient and outpatient services and sites of care provided by this hospital.

Philosophy:

San Gorgonio Memorial Hospital recognizes that a patient has the right to a safe environment, and an error free care experience. Therefore, the organization commits to a culture of safety undertaking a proactive approach to patient safety and the identification and mitigation of medical errors and environmental safety hazards.

Definitions:

In its broadest context, a **medical error** is defined as *"the failure of a planned action to be completed as intended (error of execution) or the use of a wrong plan to achieve an aim (error of planning)."*[2]

A **near miss** is any process variation that did not affect the outcome but for which a recurrence carries a significant chance of a serious adverse event.

A **hazardous condition** is any set of circumstances (exclusive of the patient's disease or condition) that significantly increase the likelihood of a serious adverse outcome.

Roles & Responsibilities:

Leadership Team:

Defines and establishes an organization-wide safety culture that includes a "code of conduct" for all employees, including contract workers. Regularly holds "open discussions" with staff caring for patients to identify safety risks & barriers to safety issues facing patients and staff. Communicates to staff when their work

improves safety. Reward and recognize those whose efforts contribute to safety. Establishes partnerships with physicians to align their incentives to improving safety and using evidence-based medicine.

Governing Body Leadership:

Final authority and responsibility for patient safety rests with the Board of Directors. This authority is delegated to the Medical/Executive Committee for review of patient safety program activities. The Medical/Executive Committee has empowered the hospital leadership and management teams with responsibility for implementing performance and patient safety improvement strategies in conjunction with the medical and hospital staff.

The Medical Staff Quality Council:

Ensures integration and assessment of organization-wide patient safety needs through data collection, measurement, and data analysis. The Quality Council participates in the selection and prioritization of high-risk, problem-prone activities, systems and performance outcomes on an annual basis. The Committee delegates specific responsibilities for safety improvement efforts to the medical staff, leadership, EOC/Safety Committee, and the hospital Patient Safety/Performance Improvement Committee and makes recommendations regarding safety to the ~~Board of Directors~~Medical Executive Committee.

Structure of Patient Safety Committees:

The Medical Staff Quality Council:

A medical staff committee responsible for quality, safety and performance concerns related to the medical staff, and the oversight of organization-wide performance improvement functions and activities (see Medical Staff Bylaws) as well as the patient safety program.

The Patient Safety/Performance Improvement Committee:

A hospital committee that focuses on hospital-wide patient safety and performance improvement monitoring and review activities including, but not limited to, department-specific performance and outcome measures designed to identify opportunities for improvement, patient satisfaction reports, multidisciplinary P.I. Team/ Task Force projects, Staff Perceptions of Patient Safety & Error Reporting, National Patient Safety Goal review and compliance reports, Sentinel Event Alerts and Gap Analysis activities, FMEA & RCA Assessments, EOC/ Hazardous Surveillance reports, etc. A Quarterly Summary report of the above activities is presented at the Medical Staff Quality Council, the Medical Executive Committee and the Hospital Board of Directors.

The Safety/Environment of Care (EOC) Committee:

Responsible for the environment of care plans and reporting, trending and evaluating activities associated with those areas including, but not limited to, proactive Environmental Safety Rounds designed to identify safety hazards in the hospital environment so that corrective actions can be implemented, Hazard Vulnerability Assessments, Disaster Preparedness activities, Environmental Safety ~~Faires~~Fairs, Security Assessments, Staff Education & Training, etc. Bi-annual Summary reports from the Safety/EOC Committee are presented and discussed at the Medical Staff Quality Council, the Medical Executive Committee and the Hospital Board.

The Infection Control & Pharmacy and Therapeutics Committee:

A medical staff committee dealing with prevention, control and surveillance of infections as well as medical therapeutic treatments, in particular blood review and medication review (see Medical staff Bylaws). The committee also oversees the required State of California Medication Error Reduction Plan (MERP) and the Antibiotic Stewardship Program. The committee reports to the Medical Staff Quality Council as appropriate and

to the Medical Executive Committee and the Hospital Board of Directors.

The Radiation Safety Committee:

A medical staff committee responsible for safety issues related to radiation safety in the diagnostic imaging department and throughout the organization. The committee reports to the Medical Executive Committee and the Hospital Board of Directors.

Program Elements:

Designing or Re-designing Systems and Processes:

When a new process is designed (or an existing process is modified) the organization will use information from both internal and external sources on designing safe systems, identifying potential failure modes, and reducing medical errors and unsafe conditions in the environment.

Identification of Potential Patient Safety Issues:

As part of its planning process, the hospital regularly reviews the scope and breadth of its services. Attendant to this review is an identification of high-risk care processes that, through the occurrence of an error, would have a significant negative impact on the health and well being of the patient. Other areas of focus include:

- Process failures and concerns identified through the organization's patient safety/performance improvement program.
- Process concerns, issues and adverse outcomes are identified through the risk management. Verge Incident Reporting System.
- Process, system and standards compliance deficiencies identified as the result of findings by regulatory and/or accrediting agencies.
- Performance deficiencies identified as a result of root cause analysis (RCA), risk assessments, gap analysis, etc.

Performance Related to Patient Safety:

- When real, or potential, safety issues/concerns have been identified through the established monitoring and review functions, mechanisms & committees of the organization, the leadership will prioritize intensified review and investigation activities based on the frequency and severity of the issue/concern, and provide the resources needed to improve the safety issue or concern.
- Performance and outcome data will be collected, aggregated, and analyzed to determine opportunities to improve high-risk processes related to patient safety and the reduction of risk to the patient population served. .
- Opportunities to reduce errors that reflect the performance of the individual care provider are addressed, as appropriate through the Medical Staff peer review process or through the hospital's human resources policy(s).

Responding to Errors:

- The hospital is committed to responding to errors in a manner that supports the rights of the patient, the clinical and emotional needs of the patient, protects the patient and others from any further risk, and preserves information critical to understanding the proximal and root cause(s) of the error. To that end, the hospital has established a variety of policies and procedures to address these issues.

Levels of Response to Errors:

There are three major levels of response by the hospital to an error. Response is based on the severity of the error.

- Errors that are minor in nature and result in little or no harm (or risk of harm) to the patient may be aggregated and analyzed to see if there are any patterns or trends that would indicate process improvement opportunities. It is generally not necessary to address each error singularly.
- Errors that are near misses or have some sort of untoward effect on the patient, but are not considered adverse events as defined by the hospital's adverse event policy, will be addressed through the hospital's quality review and risk management process. An intensive assessment or root cause analysis may or may not be performed.
- Errors that meet the hospital's definition of a Significant Adverse Event will be subjected to an intensive assessment and/or root cause analysis. (See adverse event policy).

Supporting Staff Involved in Errors:

The hospital recognizes that individuals involved in an error may need emotional and psychological support. To that end, the hospital has defined processes to assist employees and members of the Medical Staff.

- Employees can access the Employee Assistance Program for emotional support and assistance in cases of staff errors that require emotional support of the staff.
- Members of the Medical Staff can be referred to the "Physician Well Being Committee" for assistance.

Educating the Patient on Error Prevention:

- The hospital recognizes that the patient is an integral part of the healthcare team. Therefore, patients will be educated about their role and responsibility in preventing medical errors. The Joint Commission "Speak Up" campaign education brochures are utilized in the education of patients regarding their safety. The organization also utilizes the "Partnering for Safety" brochure developed by the hospital staff for distribution to the outpatient population served.

Reporting of Adverse Events:

- The hospital has established mechanisms to report occurrences of medical errors and adverse events both internally and externally.
- Errors will be entered into the Verge Incident Reporting System. Adverse events are also reported to the Appropriate manager, the Risk Manager and/or the medical staff entity,
- Errors will be reported to external agencies in accordance with applicable local, state, and federal law.

Evaluating the Effectiveness of the Program:

On an annual basis, the organization will evaluate the effectiveness of the patient safety program. Systems or process failures will be reviewed and actions taken to improve safety. A report on this evaluation will be provided to the Leadership, Patient Safety/Performance Improvement Committee, Quality Council, Medical Executive Committee, and the Governing Body.

References:

Infection Control Plan

The Environment of Care Plans

The Risk Management Plan

The Medical Error Reduction Plan

The Emergency Preparedness Plan

The Medical Staff Bylaws

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1. For the purposes of this program, the term "patient" denotes the individual receiving care, and when appropriate the patient's family or significant other. Depending upon the care setting, other terms such as "resident" or "client" may be used to denote the individual receiving care,
2. To Err is Human – Building a Safer Health System", Institute of Medicine, December 1997

Attachments:

Approval Signatures

Step Description	Approver	Date
Hospital Board of Directors	Bobbi Duffy: Executive Assistant	pending
Medical Executive Committee	Amelia Frazier: Director Medical Staff Services	01/2020
Performance Improvement Committee	Pat Ziegler: Director Performance Improvement	01/2020
Policy & Procedure Committee	Gayle Freude: Nursing Director Med/Surg	01/2020
	Pat Ziegler: Director Performance Improvement	01/2020

TAB G

MINUTES: Not Yet Approved
By Committee

A SPECIAL MEETING OF THE
SAN GORGONIO MEMORIAL HOSPITAL
BOARD OF DIRECTORS EXECUTIVE COMMITTEE
January 24, 2020

A special meeting of the San Gorgonio Memorial Hospital Board of Director's Executive Committee was held on Friday, January 24, 2020 in the Administration Boardroom, 600 N. Highland Springs Avenue, Banning, California.

Members Present: Lynn Baldi, Susan DiBiasi (C), Estelle Lewis, Ehren Ngo, Steve Rutledge

Members Absent: None

Required Staff: Steve Barron (CEO), Bobbi Duffy (Executive Assistant)

AGENDA ITEM	DISCUSSION	ACTION / FOLLOW-UP
Call To Order	Committee Chair Susan DiBiasi called the meeting to order at 3:07 pm.	
Public Comment	There was no public present at this meeting.	
OLD BUSINESS		
Proposed Action - Approve Minutes **December 17, 2019 regular meeting**	Chair DiBiasi asked for any changes or corrections to the minutes of the December 17, 2019 regular meeting. There were none.	**The minutes of the December 17, 2019 regular meeting will stand correct as presented.**
NEW BUSINESS		
Discussion and planning for Strategic Planning session	Chair DiBiasi stated that in discussing with Steve Barron what agenda items should be included in the Strategic Planning session, it was decided to involve the Executive Committee to assist in developing the agenda and planning for the day. Steve Barron reported that he has a facilitator on board who will be assisting the Board during this session. He noted that the Foundation President, Foundation Vice President and Foundation Director will be invited to attend and participate in discussions during the open session portion of the session. He and Committee	

AGENDA ITEM	DISCUSSION	ACTION / FOLLOW-UP
	members discussed a number of items and developed the following agenda schedule: **8:30 am – 9:00 am** Continental breakfast **9:00 am – 10:30 am – Open Session** Discussion of the Vision portion of the current Mission, Vision, Values statement and any suggested changes reflecting where we see the hospital going in the next 3 to 5 years. Once any changes are suggested, it will be presented to the Hospital Board for approval at a regular Board meeting. **10:30 am – 12:00 pm – Open Session** Discussion and work on developing a community benefit action plan. **12:00 pm – 12:30 pm** Buffet lunch for Hospital Board members, Foundation Board members and staff only. **12:30 pm – 2:00 pm – Open Session** Presentation regarding Diagnostic Imaging technology needs by Diagnostic Imaging Director. **2:00 pm – 3:00 pm – Closed Session** Telephone conference call with legal counsel.	
Adjourn	The meeting was adjourned at 4:18 pm.	

Minutes submitted by Bobbi Duffy, Executive Assistant

TAB H

MINUTES: Not Yet Approved By Committee

REGULAR MEETING OF THE
SAN GORGONIO MEMORIAL HOSPITAL
BOARD OF DIRECTORS

FINANCE COMMITTEE
Tuesday, January 28, 2020

The regular meeting of the San Gorgonio Memorial Hospital Board of Directors Finance Committee was held on Thursday, January 28, 2020 in the Administration Boardroom, 600 N. Highland Springs Avenue, Banning, California.

Members Present: Susan DiBiasi, Andrew Gardner, Olivia Hershey (C), Ehren Ngo, Lanny Swerdlow

Members Absent: None

Required Staff: Steve Barron (CEO), Dave Recupero (CFO), Holly Yonemoto (CBDO), Bobbi Duffy (Executive Assistant)

AGENDA ITEM	DISCUSSION	ACTION / FOLLOW-UP
Call To Order	Committee Chair Olivia Hershey, called the meeting to order at 9:01 am.	
Public Comment	There was no public present.	
OLD BUSINESS		
Proposed Action - Approve Minutes **December 19, 2019 regular meeting**	Chair Hershey asked for any changes or corrections to the minutes of the December 19, 2019 regular meeting. There were none.	**The minutes of the December 19, 2019 regular meeting will stand correct as presented.**
NEW BUSINESS		
Proposed Action – Recommend Approval to Hospital Board of Directors - Monthly Financial Report – December 2019	Chair Hershey welcomed new Finance Committee members Andrew Gardner, Ehren Ngo and Lanny Swerdlow to the meeting. Dave Recupero distributed a hard copy of the December 2019 finance report that was included on the tablets. Dave referred Committee members to page 4, "Statement of Revenue and Expense – Current Month". He noted that as shown	**M.S.C. (DiBiasi/ Ngo), the SGMH Finance Committee voted to recommend approval of the December 2019 Financial report to the Hospital Board**

AGENDA ITEM	DISCUSSION	ACTION / FOLLOW-UP
	on line 13, "Net Patient Revenue", Actual was $4,212,264, compared to the Budgeted $4,228,381. He noted that both volume and reimbursement rates came in very close to expected. He noted as shown on line 1, Inpatient Revenue, there was a negative 4.77% variance, line 3, Outpatient Revenue, showed a negative .69% variance. Line 11, Total Deductions from Revenue, shows an Actual of ($20,444,560) versus a Budgeted ($20,922,660), a 2.29% variance. This shows that we collected a higher percentage and balanced out the lower inpatient/outpatient revenues. Line 14, IGT/DSH Revenues reflects an actual of $1,467,549 versus a Budgeted $1,200,000, a positive variance of $267,549, or 22.30%. Dave noted that Total Operating Revenues were Budgeted at $6,028,492 versus an Actual of $6,201,655, an improvement of $173,163, or 2.87%. Dave referred Committee members to page 5, "Statement of Revenue and Expenses – Year-to-Date" noting that this report reflects the first 6 months of the fiscal year, July through December. As shown on line 6, Total Gross Patient Revenue, the Actual of $146,522,673 versus the Budgeted $146,250,394, reflected an improvement of $272,279. Total Operating Revenue showed an overall improvement of $2,306,835, or 6.62%. Dave distributed a handout titled "Top Line" Year-end Proj Update" noting that this was based on a recent IGT update. He stated that the IGT payments will be more than we believed and will increase from $9,920,830 to $12,203,868 for this fiscal year. This is due to the State of California doing some "catch up" and will send us 18 months instead of the normal 12 months.	**of Directors.**

<table>
<tr><th>AGENDA ITEM</th><th>DISCUSSION</th><th>ACTION / FOLLOW-UP</th></tr>
<tr><td></td><td>ROLL CALL:

<table><tr><td>DiBiasi</td><td>Yes</td><td>Gardner</td><td>Yes</td></tr><tr><td>Hershey</td><td>Yes</td><td>Ngo</td><td></td></tr><tr><td>Swerdlow</td><td>Yes</td><td colspan="2">Motion carried.</td></tr></table></td><td></td></tr>
<tr><td>Discussion/ Proposed Action – recommend approval to Hospital Board Line of Credit renewal</td><td>Dave Recupero reported that we have not yet received any line of credit draft renewal documents from Pacific Premier Bank. He noted that the process began several months ago and there have been very frequent conversations. Steve Barron reported that he will be receiving a phone call this afternoon from them but we have been told that there is no issue; it’s just taking longer than usual to put the documents together. The renewal line of credit will be for $12 million with the interest rate and covenants remaining the same as the existing line of credit.

It was discussed that the Finance Committee could recommend approval of the line of credit renewal to the Hospital Board contingent upon the terms remaining the same as discussed at today’s meeting.

ROLL CALL:

<table><tr><td>DiBiasi</td><td>Yes</td><td>Gardner</td><td>Yes</td></tr><tr><td>Hershey</td><td>Yes</td><td>Ngo</td><td>Yes</td></tr><tr><td>Swerdlow</td><td>Yes</td><td colspan="2">Motion carried.</td></tr></table></td><td>M.S.C., (DiBiasi/ Gardner), the SGMH Finance Committee voted to recommend approval of the line of credit renewal to the Hospital Board of Directors contingent upon the terms remaining the same as discussed at this meeting.</td></tr>
<tr><td>Future Agenda Items</td><td>Susan DiBiasi noted that a recommendation from the Ad Hoc Audit Selection Committee should be ready for presentation at the February Finance Committee meeting and the March Hospital Board meeting.</td><td></td></tr>
<tr><td>Next Meeting</td><td>The next Finance Committee meeting will be held on February 25, 2020.</td><td></td></tr>
<tr><td>Adjournment</td><td>The meeting was adjourned at 9:53 am.</td><td></td></tr>
</table>

In accordance with The Brown Act, *Section 54957.5*, all reports and handouts discussed during this Open Session meeting are public records and are available for public inspection. These reports and/or handouts are available for review at the Hospital Administration office located at 600 N. Highland Springs Avenue, Banning, CA 92220 during regular business hours, Monday through Friday, 8:00 am - 4:30 pm.

Minutes respectfully submitted by Bobbi Duffy, Executive Assistant

SAN GORGONIO MEMORIAL HOSPITAL
BANNING, CALIFORNIA

Unaudited Financial Statements

for

SIX MONTHs ENDING DEC 31, 2019

Certification Statement:

To the best of my knowledge, I certify for the hospital that the attached financial statements, except for the uncertainty of IGT revenue accruals, do not contain any untrue statement of a material fact or omit to state a material fact that would make the financial statements misleading. I further certify that the financial statements present in all material respsects the financial condition and results of operation of the hospital and all related organizations reported herein.

Certified by:

David D. Recupero

CFO

San Gorgonio Memorial Hospital
Financial Report – Executive Summary
For the month of December 2019 (Six months/two quarters in FY 20)

Profit/Loss (EBIDA) Summary

In the current month, there was a $12K favorable budget variance for Earnings before Interest, Depreciation and Amortization (EBIDA). December EBIDA came in at -$152K, a -2.5% EBIDA margin but was improved compared to budget. The comparison to same month last year was a decline of $263K Last December's EBIDA benefited from a one-time several hundred thousand favorable payor mix adjustment. The resulting Year-to-Date (YTD) EBIDA budget variance for this fiscal year (FY 20 over 2 quarters) is now $1.141M and was $1.563M improved over first six months of last fiscal year. Year-to-Date increase/decrease in unrestricted net assets (net profit) now shows a $1.460M loss compared to the budgeted YTD loss of $2.522M and last year's YTD loss of $3.160M.

Analysis

Referring to Patient Statistics page 9 of attached report, we see a consistent monthly trend of patient volumes coming in very close to budget. Volumes as measured by gross charges for the year actual was $146,522,000 compared to budget of $146,250,000 or a miniscule 0.19% variance. The favorable $12K EBIDA monthly December variance came mostly from higher IGT and other non-patient revenues (+$173K over budget) partially offset by expenses were (+$160K higher than budget). For the year net patient revenues of $25.272M is now +$1.05 million better than budget and $1.9 million better than last Year-to-Date.

Revenues (operating) (favorable $173K) . As mentioned above there were no volume related issues affecting this month's revenue variance instead we recorded improved accrued estimated IGT revenues (+$267K over budget). For the year favorable revenue variances of $2.3 M can be split by patient revenues up $1.05M and IGT revenues up $1.3M.

Key patient statistics variances included:
Average Daily Census (ADC) in December (25.5 actual vs 27.9 budget and 26.3 last year). YTD ADC actual= 25.6 vs budget 26.2 and last year first 6 months ADC was 24.6. YTD ED visits were 0.58% ahead of budget. Outpatient GI lab procedures had 155 procedures compared to 65 last December. Areas of declined patient activity include observation bed days (down 13.3%YTD) and outpatient surgeries (down 34.5% YTD). The over-all measurement of patient activity YTD adjusted acute discharges were down 0.52% compared to budget and up 3.59% compared to last year.

In summary, it was favorable variances in supplemental revenues for the improved financial performance in month.

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Expenses (unfavorable $160K) December expenses were higher than budget by 2.6%. The budget variance was mostly due to physician fees (anesthesia) (+$47K) and Supplies (mostly drugs) (+$193K) higher due to the timing of invoices. Year-to Date overall actual expenses are now 3.27% over budget. We have some good news in that terms are being finalized for anesthesia. We are in the process of a new contracts to be put in place in the next 3- 6 months. The potential improvement cost savings after fully implemented is at or in excess of $1.0 million annually.

BALANCE SHEET/CASH FLOW

Cash Balances fell again slightly due to the continued (as expected) low supplemental funding. We sent out $186K for IGT matching and still waiting for a $600K match. . The Cash Flow report (page 8) now shows only $1,219,685 in supplemental cash has been collected so far for the first half of the fiscal year compared to the year-end projected supplemental total of $17.7 million. Page 8 line 8 shows December patient collections of $4,141,663 compared to $3,375,239 collected in November. . We also increased the amount owed on the line of Credit to $9.0 million as a result of IGT and patient collection slowdown. The LOC contract max of $10.0 M is being renewed and hopefully increased in the new contract with the bank. Gross Days in Accounts Receivable was 64.4 in December compared to 66.3 last month, see new page 10 analysis on the AR detail by payor.

The YTD actual and projected cash picture continues to track very close to budgeted estimates.

Concluding Summary

Positive takeaways for the month:

1) Favorable variances for supplemental and IGT revenues
2) Improved (lower) legal costs for the month.
3) Continued adding to the favorable YTD EBIDA budget variance, (+$1,141,922)

Negative takeaways for the month:

1) Cash flow challenges as anticipated mostly due timing issues with IGTs
2) Higher than expected physician fees especially related to anesthesia costs.

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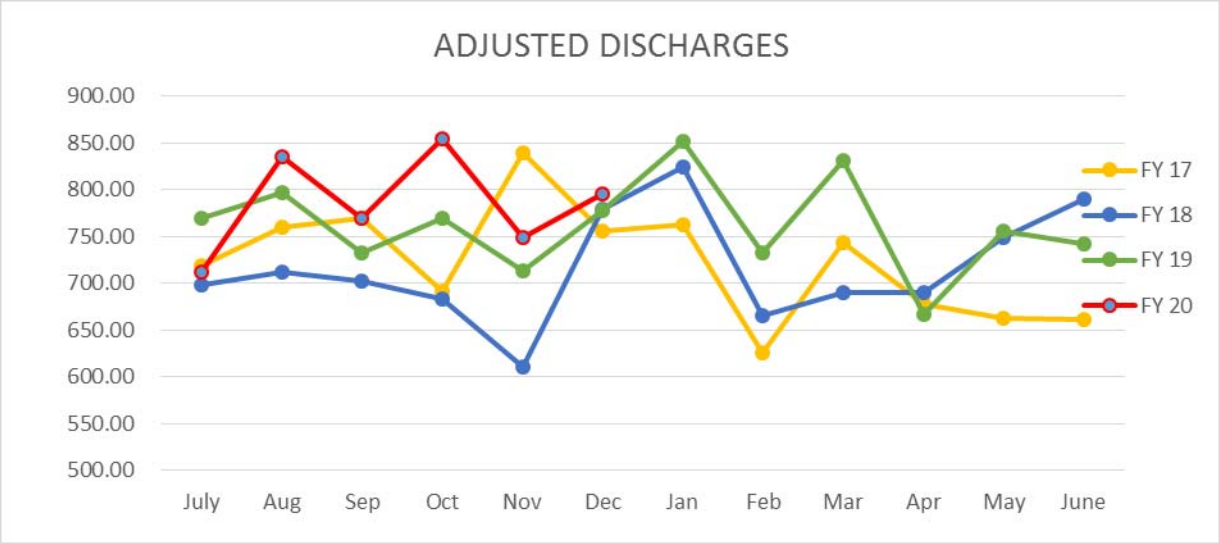
Prepared 01/16/2020
Dave Recupero, CFO



Statement of Revenue and Expense
SAN GORGONIO MEMORIAL HOSPITAL
BANNING, CALIFORNIA
SIX MONTHs ENDING DEC 31, 2019

		CURRENT MONTH				
	DISTRICT ONLY	COMBINED		Positive		Prior
	Actual 12/31/19	Actual 12/31/19	Budget 12/31/19	(Negative) Variance	Percentage Variance	Year 12/31/18
Gross Patient Revenue						
[1] Inpatient Revenue	$0	$7,473,412	$7,847,882	($374,470)	-4.77%	$7,566,427
[2] Inpatient Psych/Rehab Revenue	0	0	0	0	0.00%	0
[3] Outpatient Revenue	0	17,183,410	17,303,159	(119,749)	-0.69%	15,718,034
[4] Long Term Care Revenue	0	0	0	0	0.00%	0
[5] Home Health Revenue	0	0	0	0	0.00%	0
[6] Total Gross Patient Revenue	0	24,656,822	25,151,041	(494,219)	-1.97%	23,284,461
Deductions From Revenue						
[7] Discounts and Allowances	0	(19,143,343)	(19,972,602)	829,259	4.15%	(18,979,669)
[8] Bad Debt Expense	0	(1,140,116)	(842,940)	(297,176)	-35.25%	12,346
[9] Prior Year Settlements	0	0	(57,664)	57,664	100.00%	0
[10] Charity Care	0	(161,101)	(49,454)	(111,647)	-225.76%	(25,623)
[11] Total Deductions From Revenue	0	(20,444,560)	(20,922,660)	478,100	2.29%	(18,992,945)
[12]		82.92%	83.19%			81.57%
[13] Net Patient Revenue	0	4,212,263	4,228,381	(16,118)	-0.38%	4,291,516
Non Patient Operating Revenues						
[14] IGT/DSH Revenues	0	1,467,549	1,200,000	267,549	22.30%	824,269
[15] Tax Subsidies Measure D	188,750	188,750	200,919	(12,169)	-6.06%	175,000
[16] Tax Subsidies Prop 13	112,500	112,500	120,732	(8,232)	-6.82%	105,000
[17] Tax Subsidies County Supplemental Funds	0	0	0	0	0.00%	0
[18] Other Operating Revenue	7,656	200,495	250,707	(50,212)	-20.03%	178,073
[19] Clinic Net Revenues	20,098	20,098	27,753	(7,655)	-27.58%	31,191
Non- Patient Revenue	329,004	1,989,392	1,800,111	189,281	10.51%	1,313,533
Total Operating Revenue	**329,004**	**6,201,655**	**6,028,492**	**173,163**	**2.87%**	**5,605,049**
Operating Expenses						
[20] Salaries and Wages	0	3,339,597	3,157,929	(181,668)	-5.75%	2,940,918
[21] Fringe Benefits	0	594,620	725,524	130,904	18.04%	681,736
[22] Contract Labor	0	90,908	55,579	(35,329)	-63.57%	44,510
[23] Physicians Fees	0	242,415	195,484	(46,931)	-24.01%	251,362
[24] Purchased Services	116,528	673,414	771,900	98,486	12.76%	352,846
[25] Supply Expense	98	920,080	726,808	(193,272)	-26.59%	667,827
[26] Utilities	0	72,289	71,386	(903)	-1.27%	65,542
[27] Repairs and Maintenance	0	62,998	45,038	(17,960)	-39.88%	57,955
[28] Insurance Expense	0	91,399	101,452	10,053	9.91%	64,310
[29] All Other Operating Expenses	(18,555)	107,588	174,257	66,669	38.26%	173,895
[30] IGT Expense	0	0	0	0	0.00%	0
[31] Leases and Rentals	0	71,343	68,143	(3,200)	-4.70%	95,263
[32] Clinic Expense	63,266	87,043	99,817	12,774	12.80%	97,055
[33] **Total Operating Expenses**	**161,336**	**6,353,695**	**6,193,318**	**(160,377)**	**-2.59%**	**5,493,221**
[34] **EBIDA**	**167,668**	**(152,040)**	**(164,826)**	**12,785**	**-7.76%**	**111,828**
Interest Expense and Depreciation						
[35] Depreciation	502,454	502,454	526,000	23,546	4.48%	494,513
[36] Interest Expense and Amortization	388,662	388,662	399,474	10,812	2.71%	430,580
[37] **Total Interest & depreciation**	891,117	891,117	925,474	34,357	3.71%	925,093
Non-Operating Revenue:						
[38] Contributions & Other	0	0	16,667	(16,667)	-100.00%	0
[39] Tax Subsidies for GO Bonds - M-A	598,629	598,629	605,781	(7,152)	-1.18%	585,613
[40] **Total Non Operating Revenue/(Expense)**	**598,629**	**598,629**	**622,448**	**(23,819)**	**-3.83%**	**585,613**
[41] **Total Net Surplus/(Loss)**	**($124,820)**	**($444,528)**	**($467,852)**	**$23,324**	**-4.99%**	**($227,652)**
[42] Extra-ordinary loss on FInancing						
[43] **Increase/(Decrease in Unrestricted Net Assets**	**($124,820)**	**($444,528)**	**($467,852)**	**$23,324**	**-4.99%**	**($227,652)**
[44] **Total Profit Margin**	**-37.94%**	**-7.17%**	**-7.76%**			**-4.06%**
[45] **EBIDA %**	**50.96%**	**-2.45%**	**-2.73%**			**2.00%**

Statement of Revenue and Expense
SAN GORGONIO MEMORIAL HOSPITAL
BANNING, CALIFORNIA
SIX MONTHs ENDING DEC 31, 2019

	DISTRICT ONLY Actual 12/31/19	YEAR-TO-DATE Actual 12/31/19	Budget 12/31/19	Positive (Negative) Variance	Percentage Variance	Prior Year 12/31/18
Gross Patient Revenue						
[1] Inpatient Revenue	$0	$44,287,193	$43,615,369	$671,824	1.54%	$41,887,312
[2] Inpatient Psych/Rehab Revenue	0	0	0	0	0.00%	0
[3] Outpatient Revenue	0	102,235,480	102,635,025	(399,545)	-0.39%	98,173,776
[4] Long Term Care Revenue	0	0	0	0	0.00%	0
[5] Home Health Revenue	0	0	0	0	0.00%	0
[6] Total Gross Patient Revenue	0	146,522,673	146,250,394	272,279	0.19%	140,061,088
Deductions From Revenue						
[7] Discounts and Allowances	0	(115,976,695)	(116,501,348)	524,653	0.45%	(112,692,567)
[8] Bad Debt Expense	0	(4,799,863)	(4,901,601)	101,738	2.08%	(3,743,241)
[9] Prior Year Settlements	0	0	(335,307)	335,307	100.00%	0
[10] Charity Care	0	(474,420)	(287,567)	(186,853)	-64.98%	(260,726)
[11] Total Deductions From Revenue	0	(121,250,978)	(122,025,823)	774,845	0.63%	(116,696,534)
[12]		82.8%	83.4%	-0.7%		83.3%
[13] Net Patient Revenue	0	25,271,695	24,224,571	1,047,124	4.32%	23,364,554
Non Patient Operating Revenues						
[14] IGT/DSH Revenues	0	8,512,144	7,200,000	1,312,144	18.22%	5,354,612
[15] Tax Subsidies Measure D	1,118,750	1,118,750	1,116,626	2,124	0.19%	1,050,000
[16] Tax Subsidies Prop 13	667,500	667,500	670,981	(3,481)	-0.52%	630,000
[17] Tax Subsidies County Supplemental Funds	0	0	0	0	0.00%	0
[18] Other Operating Revenue	30,962	1,457,673	1,458,044	(371)	-0.03%	1,371,933
[19] Clinic Net Revenues	115,813	115,813	166,518	(50,705)	-30.45%	161,200
Non- Patient Revenue	1,933,024	11,871,880	10,612,169	1,259,711	11.87%	8,567,745
Total Operating Revenue	**1,933,024**	**37,143,575**	**34,836,740**	**2,306,835**	**6.62%**	**31,932,299**
Operating Expenses						
[20] Salaries and Wages	0	19,003,704	18,236,472	(767,232)	-4.21%	17,013,216
[21] Fringe Benefits	0	4,143,332	4,406,118	262,785	5.96%	4,409,883
[22] Contract Labor	0	437,609	333,474	(104,135)	-31.23%	498,805
[23] Physicians Fees	8,800	1,851,187	1,172,904	(678,283)	-57.83%	1,284,264
[24] Purchased Services	291,471	3,872,900	3,989,050	116,150	2.91%	2,487,440
[25] Supply Expense	411	4,255,595	4,171,532	(84,063)	-2.02%	3,782,458
[26] Utilities	3,000	507,666	428,316	(79,350)	-18.53%	479,638
[27] Repairs and Maintenance	6,475	334,176	270,228	(63,948)	-23.66%	304,363
[28] Insurance Expense	0	536,580	608,712	72,132	11.85%	609,724
[29] All Other Operating Expenses	47,053	879,273	1,045,542	166,269	15.90%	851,615
[30] IGT Expense	0	(201)	0	201	0.00%	0
[31] Leases and Rentals	0	425,554	408,858	(16,696)	-4.08%	830,184
[32] Clinic Expense	441,845	587,646	598,902	11,256	1.88%	636,344
[33] **Total Operating Expenses**	**799,055**	**36,835,020**	**35,670,107**	**(1,164,913)**	**-3.27%**	**33,187,934**
[34] **EBIDA**	**1,133,969**	**308,554**	**(833,367)**	**1,141,922**	**-137.03%**	**(1,255,635)**
Interest Expense and Depreciation						
[35] Depreciation	3,006,783	3,006,783	3,026,000	19,217	0.64%	3,040,153
[36] Interest Expense and Amortization	2,342,897	2,392,452	2,396,844	4,392	0.18%	2,428,511
[37] **Total Interest & depreciation**	5,349,680	5,399,235	5,422,844	23,609	0.44%	5,468,664
Non-Operating Revenue:						
[38] Contributions & Other	52,112	52,112	100,002	(47,890)	-47.89%	50,524
[39] Tax Subsidies for GO Bonds - M-A	3,578,758	3,578,758	3,634,686	(55,928)	-1.54%	3,513,675
[40] **Total Non Operating Revenue/(Expen**	**3,630,870**	**3,630,870**	**3,734,688**	**(103,818)**	**-2.78%**	**3,564,199**
[41] **Total Net Surplus/(Loss)**	**($584,841)**	**($1,459,810)**	**($2,521,523)**	**$1,061,713**	**-42.11%**	**($3,160,099)**
[42] Extra-ordinary loss on FInancing						
[43] **Increase/(Decrease in Unrestricted Net A**	**($584,841)**	**($1,459,810)**	**($2,521,523)**	**$1,061,713**	**-42.11%**	**($3,160,099)**
[44] **Total Profit Margin**	**-30.26%**	**-3.93%**	**-7.24%**			**-9.90%**
[45] **EBIDA %**	**58.66%**	**0.83%**	**-2.39%**			**-3.93%**

Balance Sheet - Assets

SAN GORGONIO MEMORIAL HOSPITAL
BANNING, CALIFORNIA
SIX MONTHs ENDING DEC 31, 2019

				ASSETS		
Percent of Net AR to Gross AR>	DISTRICT ONLY	17.68%	16.90%	Curr vs Prior Mo.	17.33%	Curr vs Prior YE
	Current Month 12/31/2019	Current Month 12/31/2019	Prior Month 11/30/2019	Positive/ (Negative) Variance	Prior Year End 06/30/2019	Positive/ (Negative) Variance
Current Assets						
[1] Cash and Cash Equivalents	$936,775	$2,627,695	$2,930,710	($303,015)	$4,175,227	($1,547,532)
[2] Gross Patient Accounts Receivable	0	51,618,798	53,311,687	(1,692,889)	49,210,703	2,408,095
[3] Less: Bad Debt and Allowance Reserves	0	(42,493,452)	(44,299,835)	1,806,382	(40,680,940)	(1,812,512)
[4] Net Patient Accounts Receivable	0	9,125,345	9,011,852	113,493	8,529,763	595,583
[5] Taxes Receivable	3,223,767	3,223,767	4,583,128	(1,359,361)	566,680	2,657,087
[6] Other Receivables	0	1,018,609	956,464	62,145	436,869	581,740
[7] Inventories	0	1,668,762	1,672,505	(3,744)	1,632,865	35,896
[8] Prepaid Expenses	116,590	504,975	512,092	(7,117)	1,326,928	(821,953)
[9] Due From Third Party Payers	0	905,508	949,604	(44,097)	554,344	351,164
[10] Malpractice Receivable	0	0	0	0	0	0
[11] IGT Receivables	0	17,770,415	16,820,653	949,763	10,058,792	7,711,623
Total Current Assets	**4,277,132**	**36,845,076**	**37,437,008**	**(591,931)**	**27,281,468**	**9,563,608**
Assets Whose Use is Limited						
[12] Cash	0	0	0	0	0	0
[13] Investments	0	0	0	0	0	0
[14] Bond Reserve/Debt Retirement Fund	7,475,698	7,481,734	5,015,234	2,466,500	8,867,208	(1,385,474)
[15] Trustee Held Funds	0	0	0	0	0	0
[16] Funded Depreciation	0	0	0	0	0	0
[17] Board Designated Funds	0	0	0	0	0	0
[18] Other Limited Use Assets	0	0	0	0	0	0
Total Limited Use Assets	**7,475,698**	**7,481,734**	**5,015,234**	**2,466,500**	**8,867,208**	**(1,385,474)**
Property, Plant, and Equipment						
[19] Land and Land Improvements	4,820,671	4,820,671	4,820,671	0	4,820,671	0
[20] Building and Building Improvements	129,283,884	129,283,884	129,283,884	0	129,283,884	0
[21] Equipment	25,869,670	25,869,670	25,848,777	20,893	25,586,875	282,794
[22] Construction In Progress	8,391,329	8,391,329	8,391,329	0	8,390,249	1,080
[23] Capitalized Interest	0	0	0	0	0	0
[24] Gross Property, Plant, and Equipment	168,365,553	168,365,553	168,344,660	20,893	168,081,679	283,874
[25] Less: Accumulated Depreciation	(74,087,997)	(74,087,997)	(73,585,543)	(502,454)	(71,114,751)	(2,973,246)
[26] **Net Property, Plant, and Equipment**	**94,277,556**	**94,277,556**	**94,759,117**	**(481,561)**	**96,966,928**	**(2,689,372)**
Other Assets						
[27] Unamortized Loan Costs	1,459,634	1,459,634	1,461,293	(1,660)	1,522,444	(62,811)
[28] Assets Held for Future Use	0	0	0	0	0	0
[29] Investments in Subsidiary/Affiliated Org.	12,153,974	0	0	0	0	0
[30] Other	0	0	0	0	0	0
[31] **Total Other Assets**	**13,613,607**	**1,459,634**	**1,461,293**	**(1,660)**	**1,522,444**	**(62,811)**
[32] **TOTAL UNRESTRICTED ASSETS**	**119,643,993**	**140,063,999**	**$138,672,652**	**$1,391,347**	**134,638,048**	**$5,425,951**
Restricted Assets	0	0	0	0	0	0
[33] **TOTAL ASSETS**	**$119,643,993**	**$140,063,999**	**$138,672,652**	**$1,391,347**	**$134,638,048**	**$5,425,951**

Balance Sheet - Liabilities and Net Assets

SAN GORGONIO MEMORIAL HOSPITAL
BANNING, CALIFORNIA
SIX MONTHs ENDING DEC 31, 2019

		District Only Current Month 12/31/2019	Current Month 12/31/2019	LIABILITIES AND FUND BALANCE Prior Month 11/30/2019	Positive/ (Negative) Variance	Prior Year End 06/30/2019	Curr vs Prior YE Positive/ (Negative) Variance
Current Liabilities							
[1]	Accounts Payable	$267,680	$5,162,622	$5,923,555	($760,933)	$4,436,438	$726,185
[2]	Notes and Loans Payable (Line of Credit)	0	9,000,000	$7,500,000	1,500,000	$0	9,000,000
[3]	Accounts Payable- Construction	0	0	$0	0	$0	0
[4]	Accrued Payroll Taxes	0	3,739,532	$3,043,151	696,380	$3,844,094	(104,563)
[5]	Accrued Benefits	0	78,111	$88,381	(10,270)	$76,513	1,599
[6]	Accrued Benefits Current Portion	0	0	$0	0	$0	0
[7]	Other Accrued Expenses	0	0	$0	0	$0	0
[8]	Accrued GO Bond Interest Payable	2,020,229	2,020,229	$1,616,183	404,046	$2,049,304	(29,075)
[9]	Malpractice Payable	0	0	$0	0	$0	0
[10]	Due to Third Party Payers (Settlements)	0	0	$0	0	$0	0
[11]	Advances From Third Party Payers	0	0	$0	0	$0	0
[12]	Current Portion of LTD (Bonds/Mortgages)	2,335,000	2,335,000	$2,335,000	0	$0	2,335,000
[13]	Current Portion of LTD (Leases)	0	0	$0	0	$0	0
[14]	Other Current Liabilities	0	35,579	13,174	22,405	15,758	19,821
	Total Current Liabilities	**4,622,909**	**22,371,073**	**20,519,445**	**1,851,628**	**10,422,106**	**11,948,966**
Long Term Debt							
[15]	Bonds/Mortgages Payable (net of Cur Portic	108,308,339	108,308,339	108,324,091	(15,753)	112,856,547	(4,548,209)
[16]	Leases Payable (net of current portion)	0	0	0	0	0	0
[17]	**Total Long Term Debt (Net of Current)**	**108,308,339**	**108,308,339**	**108,324,091**	**(15,753)**	**112,856,547**	**(4,548,209)**
Other Long Term Liabilities							
[18]	Deferred Revenue	0	0	0	0	0	0
[19]	Accrued Pension Expense (Net of Current)	0	0	0	0	0	0
[20]	Other	0	0	0	0	0	0
[21]	**Total Other Long Term Liabilities**	**0**	**0**	**0**	**0**	**0**	**0**
	TOTAL LIABILITIES	**112,931,248**	**130,679,411**	**128,843,536**	**1,835,875**	**123,278,653**	**7,400,758**
Net Assets:							
[22]	Unrestricted Fund Balance	7,297,586	10,844,398	$10,844,398	0	10,416,645	427,754
[23]	Temporarily Restricted Fund Balance	0	0	0	0	0	0
[24]	Restricted Fund Balance	0	0	0	0	0	0
[25]	Net Revenue/(Expenses)	(584,841)	(1,459,810)	(1,015,282)	(444,528)	942,750	(2,402,560)
[26]	**TOTAL NET ASSETS**	**6,712,745**	**9,384,588**	**9,829,116**	**(444,528)**	**11,359,394**	**(1,974,807)**
[27]	**TOTAL LIABILITIES AND NET ASSETS**	**$119,643,993**	**$140,063,999**	**$138,672,652**	**$1,391,347**	**$134,638,048**	**$5,425,951**
		$0	$0	$0.00		$0	

BANNING, CALIFORNIA
SIX MONTHs ENDING DEC 31, 2019

	HEALTHCARE SYSTEM MINI CASH FLOW		CASH FLOW Current Month 12/31/2019		Year-To-Date 12/31/2019
	BEGINNING CASH BALANCES				
[1]	Cash: Beginning Balances- HOSPITAL	11/30	$651,039	06/30>	1,049,179.00
[2]	Cash: Beginning Balances- DISTRICT	11/30	2,299,517	06/30>	3,126,083
[3]	Cash: Beginning Balances TOTALS	11/30	$2,930,710	06/30>	$4,175,262
	Receipts				
[4]	Pt Collections		4,141,663		24,552,692
[5]	Tax Subsidies Measure D		384,502		518,944
[6]	Tax Subsidies Prop 13		0		51,230
[7]	Tax Subsidies County Supplemental Funds		0		0
[8]	IGT & other Supplemental (see detail below)		1,027,340		491,807
[9]	Draws/(Paydown) of LOC Balances		1,500,000		9,000,000
[10]	Other Misc Receipts/Transfers		220,592		1,573,485
	TOTAL RECEIPTS		**7,274,096**		**36,188,159**
	Disbursements				
[11]	Payroll/ Benefits		3,553,487		22,846,477
[12]	Other Operating Costs		2,419,477		13,688,185
[13]	Capital Spending		20,893		283,874
[14]	Debt serv payments (Hosp onlyw/ LOC interest)		42,041		437,445
[15]	Other (increase) in AP /other bal sheet		1,541,213		353,230
[16]	**TOTAL DISBURSEMENTS**		**7,577,111**		**37,609,211**
[17]	**TOTAL CHANGE in CASH**		**(303,015)**		**(1,421,052)**
	ENDING CASH BALANCES				
[18]	Ending Balances- HOSPITAL	12/31	$1,690,920	12/31	$1,690,920
[19]	Ending Balances- DISTRICT	12/31	936,775	12/31	936,775
[20]	Ending Balances- TOTALS	12/31	$2,627,695	12/31	$2,627,695
	ADDITIONAL INFO				
[21]	LOC CURRENT BALANCES		9,000,000		9,000,000
[22]	LOC Interest Expense Incurred		35,034		126,048

	SUPPLEMENTAL CASH FLOW SUMMARY (By Program)	Current Month	Current Year-To-Date
	IGT/SUPPLEMENTAL CASH INFLOWS	**12/31/2019**	**12/31/2019**
[24]	HQAF Managed Care Funds	(148,928)	(148,928)
[25]	Prime IGT	1,050,000	525,000
[26]	Rate Range Managed Care IGTs	0	0
[27]	AB 113	0	0
[28]	HQAF FFS Direct Grants	0	503,027
[29]	IEHP MCE Bed Funds	24,396	48,792
[30]	MediCal Outpatient SRH Program	0	50,977
[31]	Foundation Contributions	0	52,112
[32]	AB 915 newly Eligible	0	0
[33]	Cost Report Settlements	0	35,514
[34]	Medi-CAL DSH	101,872	153,191
[35]	**TOTALS (see line 8 above)**	**1,027,340**	**1,219,685**

Patient Statistics

SAN GORGONIO MEMORIAL HOSPITAL
BANNING, CALIFORNIA
SIX MONTHs ENDING DEC 31, 2019

Line Ref #	Actual 12/31/19	Budget 12/31/19	Prior Year 12/31/18	STATISTICS	Year-To-Date Actual 12/31/19	Year-To-Date Budget 12/31/19	Year-To-Date Prior Year 12/31/18	YTD % VAR Vs Bud	YTD % VAR Vs Prior Yr
				Discharges					
[1]	241	271	253	Acute	1,426	1,414	1,362	0.83%	4.70%
[2]	3.30	3.20	3.08	O/P Adjustment Factor	3.31	3.35	3.34	-1.33%	-1.06%
[3]	795	868	779	Adjusted Acute Discharges	4,718	4,742	4,554	-0.52%	3.59%
[4]	19	23	26	Newborn	144	130	157	10.77%	-8.28%
[5]	260	294	279	Total Discharges	1,570	1,544	1,519	1.66%	3.36%
				Patient Days:					
[6]	791	866	816	Acute	4,713	4,817	4,535	-2.16%	3.93%
[7]	38	46	47	Newborn	288	260	287	10.77%	0.35%
[8]	829	912	863	Total Patient Days	5,001	5,077	4,822	-1.50%	3.71%
				Average Length of Stay (ALOS)					
[9]	3.28	3.20	3.23	Acute	3.31	3.41	3.33	-2.96%	-0.74%
[10]	2.0	2.0	1.8	Newborn ALOS	2.0	2.0	1.8	0.00%	9.41%
				Average Daily Census (ADC)					
[11]	25.5	27.9	26.3	Acute	25.6	26.2	24.6	-2.16%	3.93%
[12]	1.2	1.5	1.5	Newborn	1.6	1.4	1.6	10.77%	0.35%
				Emergency Dept. Statistics					
[13]	237	241	229	ED Visits - Admitted	1,275	1,257	1,190	1.39%	7.14%
[14]	1,432	1,554	1,547	ED Visits - Higher Acuity Ops	9,112	9,392	9,613	-2.98%	-5.21%
[15]	2,004	1,844	1,779	ED - Rapid Care Visits Ops	11,323	10,935	10,734	3.55%	5.49%
[16]	**3,673**	**3,639**	**3,555**	**Total ED Visits**	**21,710**	**21,584**	**21,537**	0.58%	0.80%
[17]	6.45%	6.62%	6.44%	% of ER Visits Admitted	5.87%	5.83%	5.53%	0.81%	6.29%
[18]	98.34%	88.91%	90.51%	ER Admissions as a % of Total	89.41%	88.91%	87.37%	0.56%	2.33%
				Other Key Statistics:					
[19]	4,222	4,409	4,091	Total Outpatients Visits	25,396	26,086	25,502	-2.65%	-0.42%
[20]	171	178	156	Observation Bed Days	857	988	995	-13.26%	-13.87%
[21]	17.8%	17.0%	16.0%	Obs. Bed Days as a % of Total	15.4%	17.0%	18.0%	-9.60%	-14.49%
[22]	425	535	489	Behavioral Health Visits	2,731	3,176	3,303	-14.01%	-17.32%
[23]	41	35	29	IP Surgeries	261	198	187	31.82%	39.57%
[24]	35	66	55	OP Surgeries	258	391	394	-34.02%	-34.52%
[25]	155	211	65	Outpatient Scopes	1,115	1,253	525	-11.01%	112.38%
				Productivity Statistics:					
[26]	427.92	455.70	409.69	FTE's - Worked	435.21	455.70	420.53	-4.50%	3.49%
[27]	468.29	489.60	454.03	FTE's - Paid	471.96	489.60	459.72	-3.60%	2.66%
[28]	5.08	4.78	5.06	Worked FTE's per AOB	5.14	4.78	5.10	7.44%	0.65%
[29]	5.56	5.13	5.61	Paid FTE's per AOB	5.57	5.13	5.58	8.56%	-0.16%
[30]	1.5653	1.2621	1.2621	Case Mix Index -Medicare	1.3008	1.2621	1.2621	3.06%	3.06%
[31]	1.2805	1.0419	1.0419	Case Mix Index - All payers	1.0641	1.0419	1.0419	2.13%	2.13%

AR Report

31-Dec-19

A/R & CASH FLOW TRENDS

	GROSS ACCTS RECEIVABLE BY PAYC	FY 20	Prior Year	Monthly Trends			
		31-Dec-19	FY 19	FY 20	FY 20	FY 20	FY 20
		ACTUAL	JUNE (Fiscal year-end)	SEP	OCT	NOV	DEC
1	Blue Shield	197,194	233,330	398,041	445,469	197,194	260,000
2	Blue Cross	2,362,250	1,946,555	2,690,718	2,466,779	2,362,250	2,042,815
3	MediCal	2,620,067	1,701,380	1,723,329	2,004,927	2,620,067	2,960,419
4	IEHP /Other MediCal HMO	10,725,297	6,301,624	7,410,413	10,120,703	10,725,297	7,816,990
5	Champus /Other Govt	3,336,047	2,835,303	2,787,538	3,207,902	3,336,047	3,446,635
6	HMO/PPO/Commercial	7,428,094	7,323,981	6,674,906	7,151,105	7,428,094	7,351,542
7	Medicare	5,404,188	8,498,471	7,323,482	4,639,186	5,404,188	6,097,723
8	Self Pay/Credit Bals	6,353,626	6,670,232	6,608,189	6,566,405	6,353,626	6,599,688
9	Senior HMO	14,295,098	13,054,309	14,023,136	13,521,960	14,295,098	14,385,596
10	Workers Comp	590,275	645,516	578,248	663,846	590,275	657,837
11	TOT GROSS AR	53,312,136	49,210,701	50,217,999	50,788,281	53,312,136	51,619,247

	PATIENT CASH COLLECTIONS	FY 20	FY 19	FY 20	FY 20	FY 20	FY 20
		Year-To Date	Year-To Date	SEP	OCT	NOV	DEC
12	Blue Shield	248,546	228,226	41,148	50,083	41,747	31,126
13	Blue Cross	1,131,866	1,148,320	217,692	237,896	158,720	235,167
14	Medi-Cal	1,257,027	1,409,925	366,866	189,620	147,499	207,989
15	IEHP /Other MediCal HMO	3,991,170	3,873,858	604,073	538,887	623,078	896,604
16	Champus /Other Govt	639,714	470,576	99,706	96,420	108,046	84,421
17	HMO/PPO/Commercial	4,532,502	4,396,066	648,403	731,274	627,155	694,023
18	Medicare	4,754,553	3,753,672	60,762	1,354,209	547,789	815,339
19	Self Pay/Credit Bals	766,896	724,213	132,546	134,403	132,685	86,896
20	Senior HMO	6,644,460	5,942,797	903,489	1,331,627	977,299	1,077,650
21	Workers Comp	85,938	100,540	22,534	10,609	11,220	12,446
22	TOT CASH COLLECTIONS	23,804,127	22,048,194	3,097,221	4,675,028	3,375,239	4,141,663
	Percent Change vs. Prior>						
23	% change vs. Prior yr.>		8.0%	100.3%	105.8%	116.0%	115.7%

	GROSS DAYS IN AR BY PAYOR	FY 20	FY 19	TARGET	FY 20	FY 20	FY 20	FY 20
		Year-To Date	06/30/2019	10/31/2016	SEP	OCT	NOV	DEC
24	Blue Shield	39.8	30.7	60.4	45.9	51.9	30.4	39.8
25	Blue Cross	55.6	55.6	44.6	70.4	64.2	62.4	55.6
26	MediCal	94.5	57.0	66.3	51.5	60.4	81.5	94.5
27	IEHP /Other MediCal HMO	33.7	27.3	27.5	33.2	44.1	46.6	33.7
28	Champus /Other Govt	159.7	147.6	132.2	114.5	127.8	167.1	159.7
29	HMO/PPO/Commercial	88.1	96.0	86.4	84.2	82.2	86.2	88.1
30	Medicare	51.8	58.0	36.3	62.9	38.8	47.1	51.8
31	Self Pay/Credit Bals	113.9	82.5	80.5	106.5	111.2	111.8	113.9
32	Senior HMO	69.8	64.5	59.5	69.8	64.2	67.1	69.8
33	Workers Comp	82.7	111.6	136.2	106.1	116.9	93.3	82.7
34	TOT GROSS DAYS IN AR	64.44	59.00	53.9	63.44	62.20	66.31	64.44

SAN GORGONIO HEALTH CARE SYSTEM
BANNING, CALIFORNIA
BASED on RECENT IGT UPDATE
Statement of Revenue and Expense

"TOP LINE" Year-end PROJ UPDATE

	First 6 months	Last 6 months	Projected Year-end	First 6 months	Last 6 months	Projected Year-end	
	FY 20	JAN- JUNE	BEFORE	FY 20	JAN- JUNE	AFTER	
	YTD ACT	*BUDGET*	*PROJECTIONS*	*YTD ACT*	*PROJECTIONS*	*PROJECTIONS*	*NET*
	12/31/2019	**JAN- JUNE**	**FYE 2020**	**12/31/2019**	**JAN- JUNE**	**FYE 2020**	**Improvement**
Gross Patient Revenue							
1 Inpatient Revenue	$44,287,193	$52,578,884	$96,866,077	$44,287,193	$50,578,884	$94,866,077	
8 Outpatient Revenue	$102,235,480	$106,488,591	$208,724,072	$102,235,480	$106,988,591	$209,224,072	
Total Gross Patient Revenue	146,522,673	159,067,475	305,590,148	146,522,673	157,567,475	304,090,148	
Deductions From Revenue							
10 Discounts and Allowances	($115,976,695)	($126,381,408)	($242,358,103)	($115,976,695)	($124,718,958)	($240,695,653)	
11 Bad Debt Expense	($4,799,863)	($5,331,167)	($10,131,030)	($4,799,863)	($5,161,674)	($9,961,537)	
12 GI HMO Discounts	0	(364,693)	($364,693)	0	(133,402)	($133,402)	
12 Charity Care	($474,420)	($312,771)	($787,191)	($474,420)	($510,182)	($984,602)	
Total Deductions From Revenue	(121,250,978)	(132,390,039)	(253,641,017)	(121,250,978)	(130,524,215)	(251,775,193)	
	82.75%	83.23%	83.00%	82.75%	82.75%	82.80%	
Net Patient Revenue	25,271,695	26,677,436	51,949,131	25,271,695	27,043,260	52,314,955	
Non- Patient Revenues							
14.4 IGT/DSH Revenues	$8,512,144	**$9,920,830**	$18,432,974	$8,512,144	**$12,203,868**	$20,716,012	
14 Grants & Other Op Revenues	$1,457,673	$1,577,323	$3,034,996	$1,457,673	$1,457,673	$2,915,345	
15 Clinic Net Revenues	$115,813	$166,516	$282,328	$115,813	$115,813	$231,625	
32.0 Tax Subsidies Measure D	$1,118,750	$1,346,104	$2,464,854	$1,118,750	$1,346,104	$2,464,854	
35 Tax Subsidies Prop 13	$667,500	$808,877	$1,476,377	$667,500	$808,877	$1,476,377	
36 Tax Subsidies County Supplemental Funds	$0	$195,000	$195,000	$0	$195,000	$195,000	
Non-Patient Revenues	$11,871,880	$14,014,650	$25,886,530	$11,871,880	$16,127,334	$27,999,214	
Total Operating Revenue	**37,143,575**	**40,692,086**	**77,835,661**	**37,143,575**	**43,170,594**	**80,314,169**	**2,478,508**

TAB I

SAN GORGONIO MEMORIAL HOSPITAL
Medical Staff Services Department
M E M O R A N D U M

DATE: January 15, 2020

TO: Susan DiBiasi, Chair
Governing Board

FROM: Steven Hildebrand, M.D., Chairman
Medical Executive Committee

SUBJECT: MEDICAL EXECUTIVE COMMITTEE REPORT

At the Medical Executive Committee held this date, the following item was approved, with recommendation for approval by the Governing Board:

Approval Item(s):
Policies & Procedures
The following policies and procedures are recommended for approval:

1. 2020 Patient Safety Program
   The purpose of the Patient Safety Program is to improve patient safety by focusing on problems in health care safety and how to solve them (See attached).

2. 2020 Performance Improvement Plan
   This Plan was established to improve clinical outcomes and patient experiences and reduce organizational costs (See attached).

3. Discharge Planning Evaluation
   This policy outlines discharge planning services that are provided to patients with the involvement of an interdisciplinary team. The policy also serves to reduce avoidable readmissions, and comply with all regulatory guidelines (See attached).

4. Patient Choice of Post-Acute Skilled Services Providers
   The purpose of this policy is to ensure patients are provided a meaningful choice when selecting post-hospitalization Home Health, Hospice, Long Term Acute Care, Inpatient Rehabilitation Facility or Skilled Nursing Facility services. To promote quality, cost-effective outcomes (See attached).

Annual Approval of the 2020 Prioritization Grid
The prioritization grid will assist SGMH to determine which Patient Safety Indicators and Inpatient Quality Indicator to focus on (See attached).

ACLS Certification
Physicians requesting sedation privileges, physicians who admit to ICU and anesthesiologists must have ACLS certification.

Origination:	*03/2013*
Approved:	*N/A*
Last Revised:	*01/2020*
Policy Area:	*Performance Improvement*
References:	

2020 Patient Safety Program

Purpose:

The safety and quality of care, treatment, and services depend on many factors including the following:

- An organization-wide culture that fosters safety as a priority for everyone who works in the hospital
- The planning and provision of services that meet the needs of patients
- The availability of resources – human, financial, and physical – for providing care
- The existence of competent staff and other care providers
- Ongoing evaluation of, and improvement in, performance

The Patient Safety Program is designed to support and promote the mission, vision and values of San Gorgonio Memorial Hospital. The organization–wide patient safety program is committed to promoting the safety of all patients, visitors, volunteers, physicians, healthcare workers, and students. The program is designed to reduce medical/health system errors and hazardous conditions by utilizing continuous improvement to support an organizational safety culture. A safe and just culture is promoted and supported by the organization's leadership. This plan has been implemented through the integration and coordination of the patient safety activities of multiple safety organizations, teams, task forces, committees, departments, and patient care/patient support services with responsibility for various aspects of patient and employee safety, including but not limited to:

- HEART Program Team Response to Adverse Events
- Bridge Program Management of Opioid Use
- Patient/Family Engagement Process
  ~~ED Throughput & Patient Safety~~
- Patient Experience Multidisciplinary Committee
- Data Transparency (HQI Community Engagement)
- Homeless Patient Discharge Process
- Management of Sepsis Bundle
- C-Difficle Infections Monitoring
- Periodic Survey on "Leadership Effectiveness in Establishing a Culture of Safety"
- Hospital-wide Associate Survey on Culture of Safety and Error Reporting (q 2 years)
- Security/Safety Risk Assessments
- Corporate Compliance/HIPAA
- Medical Screening Exams (in OB and ED)
- EMTALA Regulations
- Employee Health Services/Workers Compensation

- EOC/Safety Committee - Life Safety/Emergency Preparedness/Hazard Vulnerability Assessments/ Statement of Conditions, Pro-Active Environmental Safety Rounds & Corrective Action Plans and EOC Plans
- Infection Prevention and Control
- Adverse Events and Significant Near Miss Events (Root Cause Analysis and Corrective Action)
- Adverse Event Alerts Gap Analysis Improvement Process including managing risk of tubing ~~misconnection~~mis-connection during the transition to new ISO tubing connector standards.
- Improve "Hand-Off Communication" throughout the organization (Safety Survey Issue)
- Laboratory/Diagnostic Imaging Quality Control
- Materials Management/Equipment Preventive Maintenance Program
- Monitoring for the Occurrence of "Clinical and Environmental Never Events"
- Department-specific Patient Care Services Performance & Outcome Measures
- Core Measures and Meaningful Use Regulatory Compliance
- Patient Complaint & Grievance Process
- Organization-wide Performance Improvement Monitoring Activities
- Pharmacy/Medication Error Reduction Plan (MERP)/ADR & Medication Error Reporting
- Antibiotic Stewardship Program (Inpatient & Outpatient)
- Local, State & Federal Improvement Measures/Projects (i.e. CAL-HIIN, HEART and PRIME Programs)
- Medi-Cal Provider Preventable Conditions
- Continuous Survey Readiness

Scope & Applicability:

The Patient Safety Program is organization-wide in scope and applicability. Therefore, it is applicable to all inpatient and outpatient services and sites of care provided by this hospital.

Philosophy:

San Gorgonio Memorial Hospital recognizes that a patient has the right to a safe environment, and an error free care experience. Therefore, the organization commits to a culture of safety undertaking a proactive approach to patient safety and the identification and mitigation of medical errors and environmental safety hazards.

Definitions:

In its broadest context, a **medical error** is defined as *"the failure of a planned action to be completed as intended (error of execution) or the use of a wrong plan to achieve an aim (error of planning)."*[2]

A **near miss** is any process variation that did not affect the outcome but for which a recurrence carries a significant chance of a serious adverse event.

A **hazardous condition** is any set of circumstances (exclusive of the patient's disease or condition) that significantly increase the likelihood of a serious adverse outcome.

Roles & Responsibilities:

Leadership Team:

Defines and establishes an organization-wide safety culture that includes a "code of conduct" for all employees, including contract workers. Regularly holds "open discussions" with staff caring for patients to identify safety risks & barriers to safety issues facing patients and staff. Communicates to staff when their work

improves safety. Reward and recognize those whose efforts contribute to safety. Establishes partnerships with physicians to align their incentives to improving safety and using evidence-based medicine.

Governing Body Leadership:

Final authority and responsibility for patient safety rests with the Board of Directors. This authority is delegated to the Medical/Executive Committee for review of patient safety program activities. The Medical/Executive Committee has empowered the hospital leadership and management teams with responsibility for implementing performance and patient safety improvement strategies in conjunction with the medical and hospital staff.

The Medical Staff Quality Council:

Ensures integration and assessment of organization-wide patient safety needs through data collection, measurement, and data analysis. The Quality Council participates in the selection and prioritization of high-risk, problem-prone activities, systems and performance outcomes on an annual basis. The Committee delegates specific responsibilities for safety improvement efforts to the medical staff, leadership, EOC/Safety Committee, and the hospital Patient Safety/Performance Improvement Committee and makes recommendations regarding safety to the ~~Board of Directors~~Medical Executive Committee.

Structure of Patient Safety Committees:

The Medical Staff Quality Council:

A medical staff committee responsible for quality, safety and performance concerns related to the medical staff, and the oversight of organization-wide performance improvement functions and activities (see Medical Staff Bylaws) as well as the patient safety program.

The Patient Safety/Performance Improvement Committee:

A hospital committee that focuses on hospital-wide patient safety and performance improvement monitoring and review activities including, but not limited to, department-specific performance and outcome measures designed to identify opportunities for improvement, patient satisfaction reports, multidisciplinary P.I. Team/ Task Force projects, Staff Perceptions of Patient Safety & Error Reporting, National Patient Safety Goal review and compliance reports, Sentinel Event Alerts and Gap Analysis activities, FMEA & RCA Assessments, EOC/ Hazardous Surveillance reports, etc. A Quarterly Summary report of the above activities is presented at the Medical Staff Quality Council, the Medical Executive Committee and the Hospital Board of Directors.

The Safety/Environment of Care (EOC) Committee:

Responsible for the environment of care plans and reporting, trending and evaluating activities associated with those areas including, but not limited to, proactive Environmental Safety Rounds designed to identify safety hazards in the hospital environment so that corrective actions can be implemented, Hazard Vulnerability Assessments, Disaster Preparedness activities, Environmental Safety ~~Faires~~Fairs, Security Assessments, Staff Education & Training, etc. Bi-annual Summary reports from the Safety/EOC Committee are presented and discussed at the Medical Staff Quality Council, the Medical Executive Committee and the Hospital Board.

The Infection Control & Pharmacy and Therapeutics Committee:

A medical staff committee dealing with prevention, control and surveillance of infections as well as medical therapeutic treatments, in particular blood review and medication review (see Medical staff Bylaws). The committee also oversees the required State of California Medication Error Reduction Plan (MERP) and the Antibiotic Stewardship Program. The committee reports to the Medical Staff Quality Council as appropriate and

to the Medical Executive Committee and the Hospital Board of Directors.

The Radiation Safety Committee:

A medical staff committee responsible for safety issues related to radiation safety in the diagnostic imaging department and throughout the organization. The committee reports to the Medical Executive Committee and the Hospital Board of Directors.

Program Elements:

Designing or Re-designing Systems and Processes:

When a new process is designed (or an existing process is modified) the organization will use information from both internal and external sources on designing safe systems, identifying potential failure modes, and reducing medical errors and unsafe conditions in the environment.

Identification of Potential Patient Safety Issues:

As part of its planning process, the hospital regularly reviews the scope and breadth of its services. Attendant to this review is an identification of high-risk care processes that, through the occurrence of an error, would have a significant negative impact on the health and well being of the patient. Other areas of focus include:

- Process failures and concerns identified through the organization's patient safety/performance improvement program.
- Process concerns, issues and adverse outcomes are identified through the risk management. Verge Incident Reporting System.
- Process, system and standards compliance deficiencies identified as the result of findings by regulatory and/or accrediting agencies.
- Performance deficiencies identified as a result of root cause analysis (RCA), risk assessments, gap analysis, etc.

Performance Related to Patient Safety:

- When real, or potential, safety issues/concerns have been identified through the established monitoring and review functions, mechanisms & committees of the organization, the leadership will prioritize intensified review and investigation activities based on the frequency and severity of the issue/concern, and provide the resources needed to improve the safety issue or concern.
- Performance and outcome data will be collected, aggregated, and analyzed to determine opportunities to improve high-risk processes related to patient safety and the reduction of risk to the patient population served. .
- Opportunities to reduce errors that reflect the performance of the individual care provider are addressed, as appropriate through the Medical Staff peer review process or through the hospital's human resources policy(s).

Responding to Errors:

- The hospital is committed to responding to errors in a manner that supports the rights of the patient, the clinical and emotional needs of the patient, protects the patient and others from any further risk, and preserves information critical to understanding the proximal and root cause(s) of the error. To that end, the hospital has established a variety of policies and procedures to address these issues.

Levels of Response to Errors:

There are three major levels of response by the hospital to an error. Response is based on the severity of the error.

- Errors that are minor in nature and result in little or no harm (or risk of harm) to the patient may be aggregated and analyzed to see if there are any patterns or trends that would indicate process improvement opportunities. It is generally not necessary to address each error singularly.
- Errors that are near misses or have some sort of untoward effect on the patient, but are not considered adverse events as defined by the hospital's adverse event policy, will be addressed through the hospital's quality review and risk management process. An intensive assessment or root cause analysis may or may not be performed.
- Errors that meet the hospital's definition of a Significant Adverse Event will be subjected to an intensive assessment and/or root cause analysis. (See adverse event policy).

Supporting Staff Involved in Errors:

The hospital recognizes that individuals involved in an error may need emotional and psychological support. To that end, the hospital has defined processes to assist employees and members of the Medical Staff.

- Employees can access the Employee Assistance Program for emotional support and assistance in cases of staff errors that require emotional support of the staff.
- Members of the Medical Staff can be referred to the "Physician Well Being Committee" for assistance.

Educating the Patient on Error Prevention:

- The hospital recognizes that the patient is an integral part of the healthcare team. Therefore, patients will be educated about their role and responsibility in preventing medical errors. The Joint Commission "Speak Up" campaign education brochures are utilized in the education of patients regarding their safety. The organization also utilizes the "Partnering for Safety" brochure developed by the hospital staff for distribution to the outpatient population served.

Reporting of Adverse Events:

- The hospital has established mechanisms to report occurrences of medical errors and adverse events both internally and externally.
- Errors will be entered into the Verge Incident Reporting System. Adverse events are also reported to the Appropriate manager, the Risk Manager and/or the medical staff entity,
- Errors will be reported to external agencies in accordance with applicable local, state, and federal law.

Evaluating the Effectiveness of the Program:

On an annual basis, the organization will evaluate the effectiveness of the patient safety program. Systems or process failures will be reviewed and actions taken to improve safety. A report on this evaluation will be provided to the Leadership, Patient Safety/Performance Improvement Committee, Quality Council, Medical Executive Committee, and the Governing Body.

References:

Infection Control Plan

The Environment of Care Plans

The Risk Management Plan

The Medical Error Reduction Plan

The Emergency Preparedness Plan

The Medical Staff Bylaws

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1. For the purposes of this program, the term "patient" denotes the individual receiving care, and when appropriate the patient's family or significant other. Depending upon the care setting, other terms such as "resident" or "client" may be used to denote the individual receiving care,
2. To Err is Human – Building a Safer Health System", Institute of Medicine, December 1997

Attachments:

Approval Signatures

Step Description	Approver	Date
Hospital Board of Directors	Bobbi Duffy: Executive Assistant	pending
Medical Executive Committee	Amelia Frazier: Director Medical Staff Services	01/2020
Performance Improvement Committee	Pat Ziegler: Director Performance Improvement	01/2020
Policy & Procedure Committee	Gayle Freude: Nursing Director Med/Surg	01/2020
	Pat Ziegler: Director Performance Improvement	01/2020

Origination:	*03/2013*
Approved:	*N/A*
Last Revised:	*01/2020*
Policy Area:	*Performance Improvement*
References:	

2020 Performance Improvement Plan

DEFINITION:

Performance or Quality Improvement is a collaborative approach to the continuous study and improvement of the processes of providing health care services to meet the needs of consumers and others. The improvement process depends on understanding and revising processes on the basis of data, use of statistical tools for data analysis, and knowledge about the processes themselves. Performance/Quality Improvement activities involve:

- Identifying issues and establishing priorities
- Developing measures of safety, quality and performance
- Collecting data to evaluate status on outcomes, processes, or structures
- Prioritizing improvement activities based on a measurement scale
- Analyzing and interpreting data
- Making and Implementing recommendations and actions for improvement
- Assessing the effectiveness of the actions taken
- Monitoring and sustaining performance improvement

PURPOSE:

To establish and sustain an organization-wide planned, systematic, and interdisciplinary approach to improving the quality and safety of inpatient and outpatient care and services provided to the population served. The Performance Improvement Program focuses on maintaining and improving the quality and safety of important processes, systems, services and functions at San Gorgonio Memorial Hospital (SGMH). The objective is to deliver safe, cost-effective, appropriate and medically necessary quality health care and related services with competence, trust and sensitivity to our patients, physicians, and the community by the provision of patient services designed to achieve the intended outcome of the patient's treatment plan and ensure patient safety.

The fundamental principles of performance improvement are collecting data, analyzing the data, and taking actions to improve. Ongoing performance measurement includes the assessment of the key systems, processes and functions within the organization to ensure that they are designed, or redesigned, to support a culture of quality and safety. The leaders create and maintain a culture of safety and quality throughout the organization and use hospital-wide planning to establish structures and processes that focus on safety & quality. SGMH is dedicated to providing the resources and training to the staff and empowers the employees to continuously improve programs and services**.** The Administrative, Medical Staff and Hospital Board Leaders of SGMH determine performance improvement priorities annually and approve the design of the methods used

to measure and improve organization-wide performance and outcomes.

The entire organization is committed to assessing, improving and maintaining safe, high-quality, cost-effective ~~healthcare~~health care services to our patients in compliance with all applicable laws, regulations and standards. The Performance Improvement Program supports the Mission, Vision and Core Values of the hospital.

AUTHORITY AND RESPONSIBILITY:

Leaders:

The organization's leaders have ultimate responsibility for performance improvement. They set performance improvement priorities and provide the resources needed to achieve improvement. The leaders make sure that all individuals who work in the organization participate in performance improvement activities.

Board of Directors:

The SGMH Board of Directors is ultimately responsible for the safety and quality of care provided by the medical and hospital staff members. The Board reviews and approves the Performance Improvement and Patient Safety Plans and the Performance/Process Improvement Project Prioritization Grid on an annual basis.

The Board participates in the identification of priorities for improvement using the mission, vision, and values of the organization, strategic planning goals, the review of performance improvement reports and data provided by the performance improvement staff, industry and community standards and trends, regulatory agency standards, guidelines, rules & regulations, and other available resources as a basis for decision-making.

Medical Executive Committee/Quality Council:

The Board of Directors delegates the development, implementation, monitoring and evaluation of the Performance Improvement Plan to the SGMH Medical Executive Committee (MEC). The MEC is responsible for improving the quality and safety of clinical care and service provided by the hospital staff and its medical staff. The MEC utilizes the "Quality Council" to carry out part of this function. The Quality Council is a multi-disciplinary committee comprised of representatives of the governing board, medical staff, administration, performance improvement, risk management, and selected hospital directors as invited.

Administration and Management:

The Board also delegates the development, implementation, monitoring and evaluation of the P.I. Plan to the SGMH Administration and Management Team. The administration and management team are responsible for providing the time and financial resources needed to improve the operational quality of care, safety culture and services provided by SGMH and its staff.

Patient Safety/Performance Improvement Committee:

This hospital committee focuses on organization-wide patient safety and performance improvement monitoring and review activities including, but not limited to, department-specific performance and outcome measures designed to identify opportunities for improvement, patient satisfaction reports, multidisciplinary P.I. Team/ Task Force projects, staff perceptions of patient safety and error reporting, Core Measures Reports, Patient Safety Organization quality measures reports, Regulatory agency deficiencies & related action plans for correction, Compliance reports, adverse events, and gap analysis activities, failure mode effects analysis and root cause analysis assessments, EOC/hazardous surveillance reports, Provider-preventable conditions reports, etc. A Quarterly Summary report of the above activities is presented at the Medical Staff Quality Council, the Medical Executive Committee and the Governing Board meetings.

DESIGNING PROCESSES AND SERVICES:

When designing a new or modified process or service, SGMH will strive to assure that it is designed well. The following criteria are utilized to determine the effectiveness of design:

- The design is consistent with the Mission, Vision, Values and organizational objectives of SGMH.
- The design meets the needs of the individuals served, organization and medical staff, and key stakeholders.
- When clinical processes are involved, the design is sound and consistent with acceptable national and/or community standards of care.
- The design is consistent with sound business practice, and reflects stewardship of resources.
- The design, as appropriate, incorporates information about new technology and/or the performance of similar design(s) in other organizations.
- The design, as appropriate, incorporates information from other organizations about "failure modes" and the "occurrence of adverse events".
- The design incorporates the results of performance improvement activities.

ESTABLISHING PERFORMANCE MEASURES:

SGMH will establish measurements to monitor its performance and patient care outcomes. The scope of measurement will take into consideration, and be consistent with, the important care and services provided, and the critical functions of the organization.

Criteria:

The following criteria is used to determine the scope and prioritization of performance measurement and improvement:

- Assure the safety of the environment of care
- Assure the safety of the providers of care and the recipients of care
- Further the Mission and strategic objectives of SGMH
- Meet legal, regulatory, ~~licensure~~license and accreditation requirements
- Establish the effectiveness, timeliness, and stability of processes that are high-risk, high-volume or problem-prone
- Establish desirable outcomes of care for at-risk populations
- Determine the effectiveness of the design of new or modified services.

Scope of Performance Measurement:

Based on the application of the above criteria, the following care, services, and functions are monitored and/or measured:

- HEART Program Team Response to Adverse Events
- Bridge Program Management of Opioid Use
- Patient/Family Engagement Process
  ~~ED Throughput & Patient Safety~~
- **Patient Experience Multidisciplinary Committee**
- **Data Transparency (HQI Community Engagement)**
- Management of Sepsis Bundle
- C-Difficile Infection Monitoring
- Homeless Patient Discharge ~~Proces~~Process

- EMTALA Review
- Medical Screening Exams (OB & ED)
- Safety & Appropriateness of Tubing Connectors
- Risk Management/Error Prevention activities
- Utilization Review/Case Management/Discharge Planning & Social Services
- Core Measures
- Medication Error Reduction Program (MERP)
- Antibiotic Stewardship Program (Inpatient & Outpatient)
- Patient/Family Engagement Activities
- Organization-wide Culture of Safety
- Leadership Effectiveness in Establishing a Culture of Safety
- Quality Control Activities
- Staff Opinions and Education Needs
- Outcomes of Selected Processes or Services
- Autopsy Results
- BETA Healthcare Services
- Customer Satisfaction
- Control & Prevention of Infection
- Survey on Perceptions of Patient Safety & Reporting Errors in Healthcare
- Use of Medications
- Performance of Operative, Invasive and Non-Invasive Procedures that Place Patients at Risk (Inpatient & Outpatient)
- Use of Blood and Blood Components
- Use of Restraints
- Care and Service to High-Risk Populations
- Outcomes related to "Rapid Response Team" interventions and Cardio-Respiratory Resuscitation (Code Committee)
- Outcomes Related to the Use of Procedural Sedation
- Adverse Events/Significant Near Misses
- Patient Complaints/Grievance Process
- Federal & State Required Improvement Projects
- Hospital Improvement Collaboratives (CAL-HIIN, PRIME, HEART, TeamSTEPPS, etc.)
- Medi-Cal Provider Preventable Conditions
- Value-Based Purchasing Program
- Continuous Survey Readiness

Measurement of the above areas may be organization-wide in scope, targeted to specific areas, departments and services, or focused on selected populations. Measurement may also be ongoing, time-limiting, episodic, intensive, or recurring. The duration, intensity, and frequency of a particular performance measure are based on the needs of the organization, external requirements, and the result of data analysis.

Data Collection and Aggregation:

Collecting data is the foundation of performance improvement. You can't improve unless you've measured first (baseline).

Purpose:

The purpose of data collection is to:

- Establish a baseline level of performance
- Determine the stability of the process
- Determine the effectiveness of a process or desirability of an outcome as compared to internal or external targets (benchmarks)
- Identify opportunities for improvement
- Identify the need for more focused data collection
- Determine whether improvement has been achieved and/or sustained.

Structure:

Performance measures require structure to assure that data is appropriately identified, collected, aggregated, displayed, and analyzed. In general, this structure should consist of:

- A definition of the measure – including the dimensions of performance being measured
- The population to be measured (including, when appropriate, criteria for inclusion and/or exclusion
- The type of measurement (i.e. rate based or event based)
- The minimum sampling size to assure statistical validity
- The frequency of data collection/aggregation
- The methodology by which data will be collected
- The entity/individual(s) primarily responsible for data collection
- The manner in which aggregated data will be displayed
- The entity(s) to which the aggregated data will be reported to for analysis and action.

Assessment of Performance:

Data on performance measures will be analyzed to identify "opportunities for improvement". There are two (2) basic approaches utilized by SGMH to assess performance and/or outcomes:

Assessment of Aggregated Data:

Data on "rate based" performance measures are aggregated to determine patterns, trends, and variation (common or special cause). Data may be aggregated for a single point in time or over time, depending on the needs of the organization and the reason for monitoring the performance or outcome. In general, measurement designed to establish the desired stability of a process or desired outcome will be measured over time until target levels of performance are met. Once a process is considered stable, and/or a desired level of performance has been achieved, then an assessment of performance measures may be conducted in a more episodic fashion.

Data that is "event-based" is assessed in singular or aggregated form depending on the number of data elements in the performance measure. In general, event-based measurements are monitored on an ongoing basis.

Intensive Assessments:

Data will be intensively assessed when SGMH detects or suspects a significant undesirable performance or variation. Intense analysis is called for when:

- Levels of performance, patterns, or trends vary significantly and undesirably from those expected.
- Performance varies significantly and undesirably from that of other organizations or recognized standards.
- An adverse event has occurred.
- There is a confirmed hemolytic transfusion reaction.
- There is a significant medication error.

- There is a significant adverse drug reaction.
- There is a major discrepancy or pattern of discrepancy between preoperative and postoperative diagnosis – including those identified during pathologic review of specimens removed during surgical or invasive procedures.
- There is a significant adverse event associated with anesthesia.

IMPROVING PERFORMANCE:

Performance Improvement Model:

SGMH will undertake efforts to improve existing processes and outcomes, and then sustain the improved performance. The accomplish this, SGMH has adopted a performance improvement model – PDCA. This model is explained below:
P = **Plan** to Implement Action
D = **Do** Implement the Plan
C = **Check** the Results
A = **Act** on the Findings

"Rapid-Cycle PDCA" is utilized when there is a need for rapid action and improvement on a high-risk issue or concern. These performance improvement models are utilized – formally or informally – in improvement efforts throughout the organization.

Sustaining Performance:

SGMH also recognizes that in order for performance improvement to be sustained, key staff must be educated about redesign of processes or other changes that are being implemented. To that end, the following processes have been established:

- The results of performance and improvement activities are communicated, as appropriate, to the Medical Staff and hospital staff through their respective organizational structures.
- The Board of Directors receives regular reports on the organization's performance and improvement activities.
- The input of key staff is sought to identify problem-prone areas and opportunities for improvement.

Annual Evaluation:

On an annual basis, this plan will be evaluated to determine if any changes to the scope or content must be made. The SGMH Performance Improvement Director will facilitate this review. Any changes or recommendations will be forwarded to the Patient Safety/Performance Improvement Committee, the ~~Quality Council, the~~ Medical Executive Committee and the Board of Directors for review and approval.

Attachments:

Approval Signatures

Step Description	Approver	Date
Hospital Board of Directors	Bobbi Duffy: Executive Assistant	pending
Medical Executive Committee	Amelia Frazier: Director Medical Staff Services	01/2020
Performance Improvement Committee	Pat Ziegler: Director Performance Improvement	01/2020

Step Description	Approver	Date
Policy & Procedure Committee	Gayle Freude: Nursing Director Med/Surg	01/2020
	Pat Ziegler: Director Performance Improvement	01/2020

Origination:	*03/2015*
Approved:	*N/A*
Last Revised:	*11/2019*
Policy Area:	*Case Management*
References:	*42 CFR 482.30, 42 CFR 482.43, Utilization Review & Califonia HSC Section 1262.5*

Discharge Planning Evaluation

~~Discharge Planning Evaluation/Discharge Plan Formation~~

~~Policies:~~

Policy:

Patients/Patient's Representative are entitled to a post-acute care needs evaluation by, or supervised by, a Registered Nurse or social worker, early in the stay taking into account patient/patient's representative preferences in the formulation of post-acute planning. ~~Other staff~~Staff members who may participate in the discharge plan are the Clerical Case Management Assistant ~~-Clerical and~~and Licensed Vocational Nurse (LVN) Case Management Assistant ~~- LVN -~~within their scope of practice and under the supervision of a registered nurse case manager or social worker.

Procedure:

The ~~valuation~~evaluation addresses, as appropriate to the patient's presentation, the likelihood of post-acute service needs and availability of those services. The evaluation is specific to the patient, centered on the individual's needs and expressed ~~goals~~preferences where needs for case management or social work intervention are identified. The plan, as much as is possible, conforms to the patient/patient's representative stated preferences and goals ~~and preference~~ of post-acute ~~service providers~~continuum of care.

~~The evaluation procedure, for purposes of continuity of work flow, reference activities of Utilization Review for level of care screening where the tasks occur concurrently.~~

~~Interview Process/Initial Plan Formation:~~

Interview Process/Initial Plan Formation:

1. Based on ~~your~~the case manager or social worker's knowledge of the typical recovery curve for the patient's diagnoses, and the nursing and physician admission written assessments, determine ~~if a~~what degree of patient interview is needed. ~~Do this concurrent to the initial InterQual level of~~Follow for a change of condition that may indicate a more thorough assessment of post-caute care ~~screening~~needs. ~~If no needs for Case Management intervention are identified, a note to that effect~~Included in the

assessment and plan is ~~entered into the medical record~~a review of previous hospital encounters. ~~Follow for a change of condition. Included in the assessment and plan is a review of previous hospital encounters - inpatient admissions, observation stays and ED visits.~~

2. During an interview:
    a. Ask the patient/patient representative what ~~she has~~they have been told to expect by ~~her~~their doctor, and what ~~she knows~~they know about ~~her~~their treatment~~.~~
    b. Ask what the patient/patient representative anticipates in terms of post-acute care, establishing preferences
    c. As indicated, ask about and document patient experience with a ~~DME~~medical equipment vendor, Home Health Care (HHC) agency or Skilled Nursing Facility (SNF) as indicated, and if he or she is established with a primary care provider or specialist~~.~~
    d. Ask about caregiver status if a caregiver is likely to be necessary. Include in the questioning the ability, willingness and availability of caregivers
    e. ~~Question the patient about her prior living arrangement; if indicated, ask about structural adaptations.~~Question the patient/patient representative about their prior living arrangement. identify with the patient the capacity of the prior living arrangement to meet their post-acute recovery goals and preferences
    f. Question the patient/patient representative about ~~her~~their prior level of function. Include adaptive equipment used ~~or possessed.~~and/or available to them
    g. Inquire regarding prior hospital encounters for the previous 6 months as applicable. Inquire as to why frequent encounters, such as readmissions, in their estimation were necessary. Share this information with the treatment team

        ~~Assess transportation situation, if can patient afford medications and need low-cost pharmacy information, require referral to a patient assistance program with a drug's manufacturer, or prior authorization assistance.~~
    h. Assess transportation situation
    i. Assess access to prescribed medications
    j. Confer with the patient/patient representative regarding ability for self-care and the ability to return to their prior living arrangement. Establish patient preferences
    k. Obtain express permission to engage in discharge planning, involving person(s) the patient/patient representative authorizes to be involved. Include guardian and conservator involvement, Physician Order for Life Sustaining Treatment (POLST) and Advance Directives

    ~~Communicate evaluation results with PT, OT, SLP, and RT if any or all are involved in care. If you have any questions not addressed to your satisfaction in the respective discipline's notes, ask questions. Document outcome.~~

    ~~Formulate an initial plan at the time of this evaluation. Outline the plan in the medical record including interventions intended to reduce readmission risk.~~
3. Communicate evaluation results with the treatment team
4. Consider the findings and goals established by the treatment team. As appropriate communicate these findings with the patient. Reassess with the patient their goals and preferences
5. Inform the physician of your findings, proposed plan and actions toward the plan. Review CM post-acute

plan with ~~other disciplines (including the nurse). Ask questions if any discipline's~~the treatment ~~plan is unclear. (For example: is this the IV anti-infective regimen for home, or are there likely changes once initial cultures are back; are oral meds likely instead; what are the short-term goals in PT.) Record the outcome of any discussion.~~team

6. Make contact with the post-acute providers as soon after the evaluation as possible. Begin the ~~transfer~~transition of care process, documenting steps taken toward ~~transfer of care~~goals and patient preferences. ~~The expectation is that complete post~~Post-acute care ~~arrangements~~transitions are initiated as early in the stay ~~and are complete prior to the physician's decision to discharge.~~as possible in concert with the treatment team findings and recommendations

   ~~Modify the Plan as the patient's recovery dictates.~~

   ~~Keep all concerned, especially the patient or representative(s) of changes and progress toward finalizing the plan.~~

~~Documentation:~~

1. ~~At a minimum, document the interview outcome including points a – g, above.~~
2. ~~The likelihood of the need for post-acute services and the ability to obtain those services. If physical rehabilitation is involved, assess rehabilitation potential and document (in concert with the interdisciplinary team).~~
3. ~~The patient's ability for self-care, the ability to return to her prior living arrangement, and as the information can be gathered, the ability, willingness and availability of caregivers.~~
4. ~~The giving of permission to engage in discharge planning, and other person(s) the patient authorizes to be involved.~~
5. ~~A summary of the interview's implications for the discharge plan.~~

Documentation:

1. Document discharge needs assessment according to department and hospital standards
2. Include patient/patient representative preferences, resources available including those available through insurance and community programs
3. Include barriers to health care self-management
4. Conclude with a strategy based on all the above

Special note on patient's right to refuse discharge planning interventions:

~~1.Patients or their legal representatives have a right to refuse care, or set limits on what care they will accept. This includes discharge planning and post-acute care arrangements. Refusals of CM services, or restrictions on planning activity must be documented in the medical record. Documentation includes any discussion of the adverse implications of refusal of care.~~

~~2. Because a refusal can be rescinded by the patient at any time, any information gathered that will contribute to formulating and executing a discharge plan is recorded and updated as necessary.~~

~~3. A patient may demand a plan that is of questionable safety or that cannot be accommodated with available resources. Document the specifics of the patient's proposal. Discuss the patient proposed discharge plan with the physician and members of the IDT, evaluating for ways to integrate the patient's concerns into a safe and feasible discharge plan. Return to the patient or representative with the modified plan for approval.~~

1. Patients or their legal representatives have a right to refuse care, or set limits on what care they will accept. This includes discharge planning. Refusals of Case Management (CM) services, or restrictions on planning activity must be documented in the medical record. Documentation includes any discussion of the adverse implications of refusal of care.
2. Because a refusal can be rescinded by the patient at any time, any information gathered that will contribute to formulating and executing a discharge plan is recorded and updated as necessary.
3. A patient/patient representative may demand a plan that is of questionable safety or that cannot be accommodated with available resources. Patient preferences must still be considered to the degree possible. Document the specifics of the patient's/patient's representative's proposal. Discuss the patient's/ patient's representative's proposed preferences and discharge plan with the physician and members of the treatment team, evaluating for ways to integrate the patient's/patient's representative's preferences into a safe and feasible discharge plan. Return to the patient or patient's representative with the modified plan.

Attachments:

2020 Conditions of Particiation changes - discharge planning

Approval Signatures

Step Description	Approver	Date
Hospital Board of Directors	Bobbi Duffy: Executive Assistant	pending
Medical Executive Committee	Amelia Frazier: Director Medical Staff Services	01/2020
Policy & Procedure Committtee	Gayle Freude: Nursing Director Med/Surg	12/2019
	Marvin Mitchell: Director Case Management	11/2019

Origination:	*09/2015*
Approved:	*N/A*
Last Revised:	*12/2019*
Policy Area:	*Case Management*
References:	

Patient Choice of Post-Acute Skilled Services Providers

Policy

~~**Patient Choice of Providers**~~

Patients have the right to choose their providers of skilled services as part of the discharge/transitons of care~~. This extends to~~ planning: choice of Home Health Care (HHC), Hospice and Skilled Nursing Facility (SNF) providers. If transition to a ~~HHC agency or SNF~~skilled service provider is ordered, the case manager or social worker ~~involved in discharge planning~~ confers with the patient or designated decision maker to determine the patient's choice of provider. The Case Management/Social Work department maintains a current list of skilled services providers ~~of HHC and SNF services~~.

As of November 1, 2019 the patient or representative is also informed of quality and resource utilization data as found in the Medicare Nursing Home Compare, Home Heath Compare and Hospice Compare websites.

Procedure:

The HHC, SNF and Hospice list:

- Agency must be a Medicare provider
  ~~Agencies requesting to be on the list are included, unless they are not Medicare providers~~
- Agencies must be "available", meaning the agency serves the geographic area where patients will receive services. For practical purposes the list includes agencies covering Banning, Beaumont, Yucaipa, Calimesa, the Desert Cities, Cabazon, Hemet and San Jacinto areas, and the Morongo community
- The list includes providers known to be preferred providers of payers~~,~~ and medical groups ~~and medical staff, whether or not the agency has asked to be on the list~~
- ~~The list presented to a~~Guidance may be provided, tailored to the specific needs of the patient ~~may be tailored to the~~, such as specific ~~needs of the patient and limited to those within the geographic area where~~ services ~~will be rendered,~~offered (or not) physician preference ~~or~~and payer network considerations ~~(meet the Availability requirement)~~
  ~~Facilities with significant, published deficiencies such that case managers or social workers have concerns for a patient's safety may be temporarily removed from the list at the discretion of the Director for future reconsideration. Serious patient concerns brought to the attention of the Director or concerns expressed by medical staff may also result in temporary suspension from the list after investigation by the Director or designee.~~

~~Patients have the right to choose any provider, even if the patient will have to pay privately (as opposed to using a network provider). The choice to pay privately is presented as an option when selecting providers~~

- Include the Quality Measures information from the "Compare" websites. Interpretive guidance about the quality measures is allowed

~~The SNF list:~~

- ~~Facilities must be Medicare providers~~
- ~~Facilities located within the geographic service area of the hospital and surrounding communities are included (see HHC list considerations)~~
- ~~Facilities with significant, published deficiencies such that case managers or social workers have concerns for a patient's safety may be temporarily removed from the list at the discretion of the Director for future reconsideration. Serious patient concerns brought to the attention of the Director or concerns expressed by medical staff may also result in temporary suspension from the list after investigation by the Director or designee.~~
- ~~However, patients have the right to choose SNF providers despite any of the considerations, above.~~

Presenting Choices to Patient:

1. If ~~HHC or SNF~~skilled service transition of care is likely, the case manager or social worker, if not already completed during the initial discharge needs evaluation, asks the patient or designated decision maker if they have previous experience with an agency or facility, or have a preference of providers~~.~~
2. Patients or their designated decision makers have the right to choose any provider, even if the patient will have to pay privately (as opposed to using a network provider). The choice to pay privately is presented as an option when selecting providers
3. If the patient is already on service with a hospice, HHC agency, or is a resident of a SNF, the case manager asks if they may refer the patient back to that provider
4. ~~If the patient~~Only if permission is ~~already on service with a HHC agency, or is a resident of a SNF,~~given will the case manager ~~asks if they may refer the patient back to that provider. Only if permission is given will the case manager~~ or social worker begin the referral process~~.~~
5. If the patient or designated decision maker has ~~not~~ already ~~made a decision based on the information gather~~chosen a provider, ~~above,~~ the case manager or social worker ~~presents~~will still offer the list and quality data of available providers~~.~~
6. The case manager or social worker informs the patient or ~~surrogate~~designated decision maker that they have the right to choose from any available agency or facility. The patient's may choose a provider not on the hospital's list of available providers
7. The case manager or social worker advises the patient of those providers that offer any unique services necessary, as determined by the ordering physician
8. The case manager or social worker advises the patient or designated decision maker which providers are within the payer's network. If a patient chooses a non-network provider, the case manager ~~offers~~advises the patient or representative to contact the ~~provider for an estimate of charges~~payer for cost of out-of-network care
9. The social worker or case manager ~~also~~ advises the patient ~~of the following~~or designated decision maker of attending physician's or surgeon's preferences, if any. If the preference is based on treatment protocols which the HHC agency, hospice or SNF has adopted specifically to meet the physician's requirements, ~~the case manager explains~~ this is explained to the patient

10. ~~Asking for an alternate choice is generally advisable.~~Asking the patient or designated decision maker for alternate choices is generally advisable when their preferred provider is unable to provide services specific to the patient's needs
11. As much as possible, the case manager or social worker will honor the ~~wishes~~preferences of the patient or ~~authorized~~designated decision maker. If the patient's choice of providers is unavailable to ~~serve the patient by way geographic coverage, lack of services, or the inability to begin service within the time frame specified by the physician, the case manager or social worker is not obligated to follow~~meet the patient's ~~wishes~~specific needs or lacks the ability to begin service within the time frame specified by the physician, ~~but must return~~the case manager or social worker returns to the patient with an explanation and ~~to obtain~~obtains an alternate provider if one was not already identified

Attachments:

Approval Signatures

Step Description	Approver	Date
Hospital Board of Directors	Bobbi Duffy: Executive Assistant	pending
Medical Executive Committee	Amelia Frazier: Director Medical Staff Services	01/2020
Policy & Procedure Committtee	Gayle Freude: Nursing Director Med/Surg	01/2020
	Marvin Mitchell: Director Case Management	12/2019

SAN GORGONIO MEMORIAL HOSPITAL
2020 Performance/Process Improvement Project Prioritization Grid

Approved by Executive Team: _____ **Date:** 1/20/2020

Approved by Medical Executive Committee: _____ MD **Date:** 1/15/2020

Approved by Governing Board: _____ **Date:** _____

Proposed Project	Reason for Inclusion Check all that Apply						Significance of Issue			Severity of Issue			Prevalence of Issue			Total Points	Ranking	Outcome Check One			
	Low Volume = 1pt	High Risk = 1pt	Problem Prone = 1pt	Improved Outcomes = 1pt	Patient Safety = 1pt	Quality of Care = 1pt	Low Significance = 1pt	Moderate Significance = 2pt	High Significance = 3pt	Low Severity = 1pt	Moderate Severity = 2pt	High Severity = 3pt.	Isolated & Localized = 1pt	Multiple Areas = 2pt	Organization-Wide = 3pt	Enter Total Number of Points	Highest to Lowest Point Total	Project Approved	Project Tabled	Project Not Approved	Other
HEART Program Team Response to Adverse Events Organization-wide (BETA)		X	X	X	X	X			X			X			X	14	#1				
Management of Sepsis - Multidisciplinary Team (Patient Safety & Problem-Prone) Continued from 2019	X	X	X	X	X	X			X			X		X		14	#1				
Patient Experience Multidisciplinary Committee Continued from 2019		X	X	X	X	X			X			X			X	14	#1				
Patient & Family Engagement Process Multidisciplinary Team (CMS Regulation/Patient Safety)		X	X	X	X	X			X			X			X	14	#1				
Antibiotic Stewardship – Appropriate Antibiotic Use Team - Ongoing Inpatient & Outpatient	X	X	X	X	X	X			X			X		X		14	#1				
Homeless Patient Discharge Process (State Law) Continued from 2019	X	X	X	X	X	X			X				X	X		14	#1				
Bridge Program (Management of Opioid Use)	X	X	X	X	X	X			X			X		X		14	#1				
Data Transparency Team (Community Engagement) Hospital Quality Institute	X		X					X						X		6	#2				

TAB J

POLICIES AND PROCEDURES FOR BOARD APPROVAL - Hospital Board meeting of February 4, 2020

	Title	Policy Area	Owner	Workflow Approval
1	2020 Environmental Safety and Security Management Plan	Emergency Preparedness	Joey Hunter, Director	Bobbi Duffy for Hospital Board of Directors
2	2020 Patient Safety program	Performance Improvement	Pat Ziegler, Director	Bobbi Duffy for Hospital Board of Directors
3	2020 Performance Improvement Plan	Performance Improvement	Pat Ziegler, Director	Boar
4	Civil Disturbance or Unrest	Emergency Preparedness	Joey Hunter, Director	Bobbi Duffy for Hospital Board of Directors
5	Code Gray - Combative Person	Security	Joey Hunter, Director	Bobbi Duffy for Hospital Board of Directors
6	Discharge Planning Evaluation	Case Management	Marvin Mitchell, Director	Bobbi Duffy for Hospital Board of Directors
7	Dry Food Storage	Dietary	Lakeisha Hawthorne, Director	Bobbi Duffy for Hospital Board of Directors
8	Liquid Puree Diet	Dietary	Lakeisha Hawthorne, Director	Bobbi Duffy for Hospital Board of Directors
9	Patient Choice of Post-Acute Skilled Services Providers	Case Management	Marvin Mitchell, Director	Bobbi Duffy for Hospital Board of Directors
10	Wound Debridement - Standardized Procedure	Nursing	Pat Brown, CNO	Bobbi Duffy for Hospital Board of Directors

SAN GORGONIO MEMORIAL HOSPITAL

Origination:	*03/2013*
Approved:	*N/A*
Last Revised:	*01/2020*
Policy Area:	*Emergency Preparedness*
References:	

2020 Environmental Safety and Security Management Plan

I. PURPOSE:

The Environmental Safety and Security Management Plan has combined two of planning documents, which are designed to provide a safe, secure, functional, supportive, and effective environment for patients, associates, visitors and all others utilizing the facility(s).

II. GOALS & OBJECTIVES:

~~A. The 2018~~The 2020 Goals and ~~objectives for the~~Objectives for Environmental Safety and Security Plan are based on past performance, data analysis, and information from both internal and external sources. These goals and objectives will have leadership oversight with approval from the hospital governing board and the Environment of Care (EOC)/Safety Committee, and will be reported on a quarterly basis, or sooner if deemed appropriate by the Chief Executive Officer (CEO) or the Chief Nursing Officer (CNO).

- Identification of an individual(s) to manage, coordinate, and mitigate risk reduction activities in the physical environment through data collection and dissemination, which will lead to appropriate actions and results.
- Identification of an individual(s) to intervene whenever an environmental safety or security condition immediately ~~threatens~~threaten life or health, or damage to the property or the environment.
- To incorporate an effective process of identifying individuals entering and/or leaving the facility(s).
- Development of appropriate policies and procedures for controlling the access to and from departments, which are identified as security sensitive.
- Establishment of appropriate policies and procedures to follow in the event of a security incident, such as: a Code Gray, Code Silver (Active Shooter), Code Pink, Code Yellow, as well as a partial or complete lock -down of a department or the entire facility(s).
- Promote the newly developed Workplace Violence Prevention Program and Policy, including review and reporting of trends and incidents. These reports will be compiled by the Environmental Safety Officer, who will assemble a Threat Assessment Team as per policy, to ensure appropriate investigation of all incidents, especially those which are the result of an identified environmental safety, security issue or potential workplace violence.
- Increase staff awareness of potentially dangerous situations by increasing staff knowledge in workplace violence, by establishing a comprehensive workplace violence program for associates, medical staff and volunteers. The training will include how and when to report workplace violence.
- Ensure compliance of a non-smoking campus by patients, associates, visitors, and others utilizing the facility.

- Present new hires, department directors, associates, medical staff, volunteers and/ or contractors, annual and on-going training in environmental safety and security.
  ~~Promote the newly developed Workplace Violence Prevention Program and Policy, including review and reporting of trends and incidents. These reports will be compiled by the Environmental Safety Officer, who will assemble a Threat Assessment Team as per policy, to ensure appropriate investigation of all incidents, especially those which are the result of an identified environmental safety, security issue or potential workplace violence.~~
- Ensure that an annual, proactive ~~Environmental Safety and Security Threat Assessment~~environmental safety and security risk assessment is conducted which may include input from local law enforcement. The information from the assessment will be reported to the hospital governing board, the Executive Team and the EOC/Safety Committee.
- Ensure that identified potential ~~environmental safety and security~~Environmental Safety and Security threats from the Environmental Safety and Security ~~Threat Assessment~~Risk assessment, are incorporated into future plans in order to mitigate the threat, risk and potential impact on the organization and the community, as a whole.

III. **SCOPE AND APPLICABILITY:**

The Environmental Safety and Security Management Plan is organization-wide in scope and applies to all inpatient and outpatient care settings, departments, and services.

IV. **AUTHORITY:**

A. The Environmental Safety and Security Management Plan is authorized by San Gorgonio Memorial Hospital's (SGMH) governing board. The CEO delegates the monitoring of the Environmental Safety and Security Management Plan and Program to the Environmental Safety Officer, who will work in collaboration with the EOC/Safety Committee members.

B. The EOC/Safety Committee is currently chaired by the Director of Engineering and is intended to be a multidisciplinary committee with representation from the hospital governing board, Administration, Clinical Laboratory, Diagnostic Imagining, Dietary Services, Emergency Preparedness, the Emergency Department, Employee Health, Engineering, Environmental Services, Human Resources, Infection Control/Risk Management, Materials Management, Medical Staff, Nursing Leadership, Performance Improvement, Security and Surgical Services.

V. **PROGRAM ELEMENTS:**

- Development, implementation and maintenance of the Environmental Safety and Security Plan and the processes that will be used to effectively manage the environmental safety and security of patients, associates, visitors and all others utilizing the facility(s).
- Identification of an individual who will identify, manage, and coordinate environmental safety and security risk reduction activities in the physical environment, through data collection and dissemination, which will lead to appropriate actions and results.
- Identification of an individual to intervene whenever environmental safety and security conditions immediately threaten life, health, or the property of the organization (equipment and/or buildings).
- Identification of environmental safety and security risks associated with the environment of care.
- Identification of individuals entering the facility.
- Control of the access to and from areas that are identified as security sensitive within the facility.
- Ensure that effective policies and procedures are in place to be followed in the event of a security incident, including an infant or pediatric abduction, as well as a workplace violence incident.
- Respond, review, and collection of data regarding injuries to patients, associates, and/or others within the

facility which are or could potentially have been caused by an environmental safety and security issue or practice and/or the result of workplace violence.
- Establish and maintain environmental safety and security policies and procedures, which will be reviewed for effectiveness as needed, but at least once every three years.
- Report and investigate all other incidents, which result in injury to patients, associates, visitors, and others utilizing the facility including property damage and "never events," in collaboration with the EOC/Safety Committee members.
- Reports on this plan, goals, objectives and plan elements will be presented quarterly to the hospital governing board, the EOC/Safety Committee, ~~the Patient Safety/Performance Improvement Committee,~~ or as deemed appropriate by the Chief Executive Officer (CEO ~~or CNO~~) or Chief Nursing Executive (CNE).

VI. **ADDITIONAL PROGRAM ELEMENTS:**

- The multi-disciplinary EOC/Safety Committee shall report, collect data, analyze, investigate, and take required action on additional program elements. These additional program elements will include, but is not necessarily limited to the following:
  - Conducting environmental tours ~~every six months~~ in patient care areas to evaluate the effectiveness of previously implemented activities intended to minimize or eliminate environment of care risks
  - Conducting annual environmental tours in non-patient care areas to evaluate the effectiveness of previously implemented activities intended to minimize or eliminate risks in the environment.
  - Occupational illnesses and staff injuries, including any workplace violence incidents
  - Responding to product notices and recalls
  - Hazardous materials and waste spills and exposures
  - Fire safety management problems, deficiencies and failures
  - Medical or laboratory equipment management problems, failures and use errors
  - Utility systems management problems, failures or use errors

VII. **EDUCATION AND TRAINING:**

A. Environmental Safety and Security training is provided to all associates at new hire, general orientation. Additional education and training is provided by the Environmental Safety Officer, the Security department and/or members of the EOC/Safety Committee, as needed and to include attendance at departmental staff meetings. However, at San Gorgonio Memorial Hospital, environmental safety and security is everyone~~'~~'s responsibility and all associates are encouraged to report or say something immediately, if they see something that ~~doesn't~~doesn't appear safe, secure, or looks suspicious.

B. Additional education on department specific and general environmental safety and security topics, are available to associates on-line with competencies to be completed, in order to ensure understanding.

C. The Environmental Safety Officer in collaboration with the EOC/Safety Committee will coordinate an annual organization-wide environmental safety and security education program event, by providing two Annual Environmental Safety Fairs.

VIII. **OTHER TRAINING:**

- Department level training is provided to educate associates to specific job-related hazards and is assessed and monitored by Department Directors or designee.
- EOC/Safety Inspection Rounds, regulatory surveys, emergency code exercises and drills are utilized to ensure associates are following appropriate environmental safety and security practices, evaluate associate understanding of practices, policies and procedures as well as provide "just in time" training to

prepare associates and help them become more comfortable in responding to and recovering from an actual incident or emergency code.
- All education and training programs are conducted in accordance with state and federal regulatory requirements in an effort to reduce the risk of workplace injury, exposure, and/or violence.
- As new or revised environmental safety or security regulations are established, they will be presented to associates promptly through appropriate training and/or education programs, as required to ensure understanding.
- Environmental safety and security education is also provided for associates, through articles published in the hospital newsletter and information posted in display cases, outside of the cafeteria and other locations throughout the facility, if required.

IX. **PERFORMANCE MEASUREMENT:**

A. In an effort to improve Environmental Safety and Security and assist in meeting annual goals and objectives of this plan, performance measures will be monitored and evaluated on an on-going basis throughout the organization to determine effectiveness.

B. Performance measures for the coming year include (but are not limited to):

- Monitoring for environmental "never events"
- Assess associates knowledge regarding environmental safety and security policies and procedure by conducting emergency ~~code~~ exercises/drills. Any corrective actions items identified will be addressed in an After Action Report and will include a Improvement Plan, which assigns the associate responsible and a time line for completion to ensure appropriate follow-up.
- Conduct at least one Code Pink (infant/child abduction) exercise annually.
- ~~Conduct a least one Code Silver (active shooter/weapons situation) exercise and/or Code Yellow (bomb threat or suspicious package) exercise annually.~~
- ~~Ensure appropriate reporting and follow-up on findings from the annual Environmental Safety and Security Threat Assessment.~~

X. PROGRAM EVALUATION:

A. The goals, objectives, scope, and performance measures of the Environmental Safety and Security Management Plan will be evaluated on an annual basis. Revisions and/or changes in laws regulations and standards will be addressed as part of the annual evaluation process and incorporated into the Environmental Safety and Security Management Program and Plan for the coming year.

B. Annual evaluation of the plan and any revisions to the plan for the coming year will be done with leadership oversight and reported to the hospital governing board and EOC/Safety Committee annually, or sooner if indicated.

REFERENCES

1. CIHQ ~~Standard~~Standards CE-3, CE-4
2. CMS Conditions of Participation for Acute Care Hospitals – §482.41(a)
3. California Health and Safety Code Sections 1250 and 1257
4. Labor Code Section 6401.8, Occupational Safety and Health

Attachments:

Approval Signatures

Step Description	Approver	Date
Hospital Board of Directors	Bobbi Duffy: Executive Assistant	pending
Environment of Care Committee	Dan Mares: Director Engineering	01/2020
Policy & Procedure Committee	Gayle Freude: Nursing Director Med/Surg	01/2020
	Joey Hunter: Director Emergency Preparedness, EOC & Security	01/2020

Origination:	*03/2013*
Approved:	*N/A*
Last Revised:	*01/2020*
Policy Area:	*Performance Improvement*
References:	

2020 Patient Safety Program

Purpose:

The safety and quality of care, treatment, and services depend on many factors including the following:

- An organization-wide culture that fosters safety as a priority for everyone who works in the hospital
- The planning and provision of services that meet the needs of patients
- The availability of resources – human, financial, and physical – for providing care
- The existence of competent staff and other care providers
- Ongoing evaluation of, and improvement in, performance

The Patient Safety Program is designed to support and promote the mission, vision and values of San Gorgonio Memorial Hospital. The organization–wide patient safety program is committed to promoting the safety of all patients, visitors, volunteers, physicians, healthcare workers, and students. The program is designed to reduce medical/health system errors and hazardous conditions by utilizing continuous improvement to support an organizational safety culture. A safe and just culture is promoted and supported by the organization's leadership. This plan has been implemented through the integration and coordination of the patient safety activities of multiple safety organizations, teams, task forces, committees, departments, and patient care/patient support services with responsibility for various aspects of patient and employee safety, including but not limited to:

- HEART Program Team Response to Adverse Events
- Bridge Program Management of Opioid Use
- Patient/Family Engagement Process
  ~~ED Throughput & Patient Safety~~
- Patient Experience Multidisciplinary Committee
- Data Transparency (HQI Community Engagement)
- Homeless Patient Discharge Process
- Management of Sepsis Bundle
- C-Difficle Infections Monitoring
- Periodic Survey on "Leadership Effectiveness in Establishing a Culture of Safety"
- Hospital-wide Associate Survey on Culture of Safety and Error Reporting (q 2 years)
- Security/Safety Risk Assessments
- Corporate Compliance/HIPAA
- Medical Screening Exams (in OB and ED)
- EMTALA Regulations
- Employee Health Services/Workers Compensation

- EOC/Safety Committee - Life Safety/Emergency Preparedness/Hazard Vulnerability Assessments/ Statement of Conditions, Pro-Active Environmental Safety Rounds & Corrective Action Plans and EOC Plans
- Infection Prevention and Control
- Adverse Events and Significant Near Miss Events (Root Cause Analysis and Corrective Action)
- Adverse Event Alerts Gap Analysis Improvement Process including managing risk of tubing ~~misconnection~~mis-connection during the transition to new ISO tubing connector standards.
- Improve "Hand-Off Communication" throughout the organization (Safety Survey Issue)
- Laboratory/Diagnostic Imaging Quality Control
- Materials Management/Equipment Preventive Maintenance Program
- Monitoring for the Occurrence of "Clinical and Environmental Never Events"
- Department-specific Patient Care Services Performance & Outcome Measures
- Core Measures and Meaningful Use Regulatory Compliance
- Patient Complaint & Grievance Process
- Organization-wide Performance Improvement Monitoring Activities
- Pharmacy/Medication Error Reduction Plan (MERP)/ADR & Medication Error Reporting
- Antibiotic Stewardship Program (Inpatient & Outpatient)
- Local, State & Federal Improvement Measures/Projects (i.e. CAL-HIIN, HEART and PRIME Programs)
- Medi-Cal Provider Preventable Conditions
- Continuous Survey Readiness

Scope & Applicability:

The Patient Safety Program is organization-wide in scope and applicability. Therefore, it is applicable to all inpatient and outpatient services and sites of care provided by this hospital.

Philosophy:

San Gorgonio Memorial Hospital recognizes that a patient has the right to a safe environment, and an error free care experience. Therefore, the organization commits to a culture of safety undertaking a proactive approach to patient safety and the identification and mitigation of medical errors and environmental safety hazards.

Definitions:

In its broadest context, a **medical error** is defined as *"the failure of a planned action to be completed as intended (error of execution) or the use of a wrong plan to achieve an aim (error of planning)."*[2]

A **near miss** is any process variation that did not affect the outcome but for which a recurrence carries a significant chance of a serious adverse event.

A **hazardous condition** is any set of circumstances (exclusive of the patient's disease or condition) that significantly increase the likelihood of a serious adverse outcome.

Roles & Responsibilities:

Leadership Team:

Defines and establishes an organization-wide safety culture that includes a "code of conduct" for all employees, including contract workers. Regularly holds "open discussions" with staff caring for patients to identify safety risks & barriers to safety issues facing patients and staff. Communicates to staff when their work

improves safety. Reward and recognize those whose efforts contribute to safety. Establishes partnerships with physicians to align their incentives to improving safety and using evidence-based medicine.

Governing Body Leadership:

Final authority and responsibility for patient safety rests with the Board of Directors. This authority is delegated to the Medical/Executive Committee for review of patient safety program activities. The Medical/Executive Committee has empowered the hospital leadership and management teams with responsibility for implementing performance and patient safety improvement strategies in conjunction with the medical and hospital staff.

The Medical Staff Quality Council:

Ensures integration and assessment of organization-wide patient safety needs through data collection, measurement, and data analysis. The Quality Council participates in the selection and prioritization of high-risk, problem-prone activities, systems and performance outcomes on an annual basis. The Committee delegates specific responsibilities for safety improvement efforts to the medical staff, leadership, EOC/Safety Committee, and the hospital Patient Safety/Performance Improvement Committee and makes recommendations regarding safety to the ~~Board of Directors~~Medical Executive Committee.

Structure of Patient Safety Committees:

The Medical Staff Quality Council:

A medical staff committee responsible for quality, safety and performance concerns related to the medical staff, and the oversight of organization-wide performance improvement functions and activities (see Medical Staff Bylaws) as well as the patient safety program.

The Patient Safety/Performance Improvement Committee:

A hospital committee that focuses on hospital-wide patient safety and performance improvement monitoring and review activities including, but not limited to, department-specific performance and outcome measures designed to identify opportunities for improvement, patient satisfaction reports, multidisciplinary P.I. Team/ Task Force projects, Staff Perceptions of Patient Safety & Error Reporting, National Patient Safety Goal review and compliance reports, Sentinel Event Alerts and Gap Analysis activities, FMEA & RCA Assessments, EOC/ Hazardous Surveillance reports, etc. A Quarterly Summary report of the above activities is presented at the Medical Staff Quality Council, the Medical Executive Committee and the Hospital Board of Directors.

The Safety/Environment of Care (EOC) Committee:

Responsible for the environment of care plans and reporting, trending and evaluating activities associated with those areas including, but not limited to, proactive Environmental Safety Rounds designed to identify safety hazards in the hospital environment so that corrective actions can be implemented, Hazard Vulnerability Assessments, Disaster Preparedness activities, Environmental Safety ~~Faires~~Fairs, Security Assessments, Staff Education & Training, etc. Bi-annual Summary reports from the Safety/EOC Committee are presented and discussed at the Medical Staff Quality Council, the Medical Executive Committee and the Hospital Board.

The Infection Control & Pharmacy and Therapeutics Committee:

A medical staff committee dealing with prevention, control and surveillance of infections as well as medical therapeutic treatments, in particular blood review and medication review (see Medical staff Bylaws). The committee also oversees the required State of California Medication Error Reduction Plan (MERP) and the Antibiotic Stewardship Program. The committee reports to the Medical Staff Quality Council as appropriate and

to the Medical Executive Committee and the Hospital Board of Directors.

The Radiation Safety Committee:

A medical staff committee responsible for safety issues related to radiation safety in the diagnostic imaging department and throughout the organization. The committee reports to the Medical Executive Committee and the Hospital Board of Directors.

Program Elements:

Designing or Re-designing Systems and Processes:

When a new process is designed (or an existing process is modified) the organization will use information from both internal and external sources on designing safe systems, identifying potential failure modes, and reducing medical errors and unsafe conditions in the environment.

Identification of Potential Patient Safety Issues:

As part of its planning process, the hospital regularly reviews the scope and breadth of its services. Attendant to this review is an identification of high-risk care processes that, through the occurrence of an error, would have a significant negative impact on the health and well being of the patient. Other areas of focus include:

- Process failures and concerns identified through the organization's patient safety/performance improvement program.
- Process concerns, issues and adverse outcomes are identified through the risk management. Verge Incident Reporting System.
- Process, system and standards compliance deficiencies identified as the result of findings by regulatory and/or accrediting agencies.
- Performance deficiencies identified as a result of root cause analysis (RCA), risk assessments, gap analysis, etc.

Performance Related to Patient Safety:

- When real, or potential, safety issues/concerns have been identified through the established monitoring and review functions, mechanisms & committees of the organization, the leadership will prioritize intensified review and investigation activities based on the frequency and severity of the issue/concern, and provide the resources needed to improve the safety issue or concern.
- Performance and outcome data will be collected, aggregated, and analyzed to determine opportunities to improve high-risk processes related to patient safety and the reduction of risk to the patient population served. .
- Opportunities to reduce errors that reflect the performance of the individual care provider are addressed, as appropriate through the Medical Staff peer review process or through the hospital's human resources policy(s).

Responding to Errors:

- The hospital is committed to responding to errors in a manner that supports the rights of the patient, the clinical and emotional needs of the patient, protects the patient and others from any further risk, and preserves information critical to understanding the proximal and root cause(s) of the error. To that end, the hospital has established a variety of policies and procedures to address these issues.

Levels of Response to Errors:

There are three major levels of response by the hospital to an error. Response is based on the severity of the error.

- Errors that are minor in nature and result in little or no harm (or risk of harm) to the patient may be aggregated and analyzed to see if there are any patterns or trends that would indicate process improvement opportunities. It is generally not necessary to address each error singularly.
- Errors that are near misses or have some sort of untoward effect on the patient, but are not considered adverse events as defined by the hospital's adverse event policy, will be addressed through the hospital's quality review and risk management process. An intensive assessment or root cause analysis may or may not be performed.
- Errors that meet the hospital's definition of a Significant Adverse Event will be subjected to an intensive assessment and/or root cause analysis. (See adverse event policy).

Supporting Staff Involved in Errors:

The hospital recognizes that individuals involved in an error may need emotional and psychological support. To that end, the hospital has defined processes to assist employees and members of the Medical Staff.

- Employees can access the Employee Assistance Program for emotional support and assistance in cases of staff errors that require emotional support of the staff.
- Members of the Medical Staff can be referred to the "Physician Well Being Committee" for assistance.

Educating the Patient on Error Prevention:

- The hospital recognizes that the patient is an integral part of the healthcare team. Therefore, patients will be educated about their role and responsibility in preventing medical errors. The Joint Commission "Speak Up" campaign education brochures are utilized in the education of patients regarding their safety. The organization also utilizes the "Partnering for Safety" brochure developed by the hospital staff for distribution to the outpatient population served.

Reporting of Adverse Events:

- The hospital has established mechanisms to report occurrences of medical errors and adverse events both internally and externally.
- Errors will be entered into the Verge Incident Reporting System. Adverse events are also reported to the Appropriate manager, the Risk Manager and/or the medical staff entity,
- Errors will be reported to external agencies in accordance with applicable local, state, and federal law.

Evaluating the Effectiveness of the Program:

On an annual basis, the organization will evaluate the effectiveness of the patient safety program. Systems or process failures will be reviewed and actions taken to improve safety. A report on this evaluation will be provided to the Leadership, Patient Safety/Performance Improvement Committee, Quality Council, Medical Executive Committee, and the Governing Body.

References:

Infection Control Plan

The Environment of Care Plans

The Risk Management Plan

The Medical Error Reduction Plan

The Emergency Preparedness Plan

The Medical Staff Bylaws

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1. For the purposes of this program, the term "patient" denotes the individual receiving care, and when appropriate the patient's family or significant other. Depending upon the care setting, other terms such as "resident" or "client" may be used to denote the individual receiving care,
2. To Err is Human – Building a Safer Health System", Institute of Medicine, December 1997

Attachments:

Approval Signatures

Step Description	Approver	Date
Hospital Board of Directors	Bobbi Duffy: Executive Assistant	pending
Medical Executive Committee	Amelia Frazier: Director Medical Staff Services	01/2020
Performance Improvement Committee	Pat Ziegler: Director Performance Improvement	01/2020
Policy & Procedure Committee	Gayle Freude: Nursing Director Med/Surg	01/2020
	Pat Ziegler: Director Performance Improvement	01/2020

Origination:	*03/2013*
Approved:	*N/A*
Last Revised:	*01/2020*
Policy Area:	*Performance Improvement*
References:	

2020 Performance Improvement Plan

DEFINITION:

Performance or Quality Improvement is a collaborative approach to the continuous study and improvement of the processes of providing health care services to meet the needs of consumers and others. The improvement process depends on understanding and revising processes on the basis of data, use of statistical tools for data analysis, and knowledge about the processes themselves. Performance/Quality Improvement activities involve:

- Identifying issues and establishing priorities
- Developing measures of safety, quality and performance
- Collecting data to evaluate status on outcomes, processes, or structures
- Prioritizing improvement activities based on a measurement scale
- Analyzing and interpreting data
- Making and Implementing recommendations and actions for improvement
- Assessing the effectiveness of the actions taken
- Monitoring and sustaining performance improvement

PURPOSE:

To establish and sustain an organization-wide planned, systematic, and interdisciplinary approach to improving the quality and safety of inpatient and outpatient care and services provided to the population served. The Performance Improvement Program focuses on maintaining and improving the quality and safety of important processes, systems, services and functions at San Gorgonio Memorial Hospital (SGMH). The objective is to deliver safe, cost-effective, appropriate and medically necessary quality health care and related services with competence, trust and sensitivity to our patients, physicians, and the community by the provision of patient services designed to achieve the intended outcome of the patient's treatment plan and ensure patient safety.

The fundamental principles of performance improvement are collecting data, analyzing the data, and taking actions to improve. Ongoing performance measurement includes the assessment of the key systems, processes and functions within the organization to ensure that they are designed, or redesigned, to support a culture of quality and safety. The leaders create and maintain a culture of safety and quality throughout the organization and use hospital-wide planning to establish structures and processes that focus on safety & quality. SGMH is dedicated to providing the resources and training to the staff and empowers the employees to continuously improve programs and services**.** The Administrative, Medical Staff and Hospital Board Leaders of SGMH determine performance improvement priorities annually and approve the design of the methods used

to measure and improve organization-wide performance and outcomes.

The entire organization is committed to assessing, improving and maintaining safe, high-quality, cost-effective ~~healthcare~~health care services to our patients in compliance with all applicable laws, regulations and standards. The Performance Improvement Program supports the Mission, Vision and Core Values of the hospital.

AUTHORITY AND RESPONSIBILITY:

Leaders:

The organization's leaders have ultimate responsibility for performance improvement. They set performance improvement priorities and provide the resources needed to achieve improvement. The leaders make sure that all individuals who work in the organization participate in performance improvement activities.

Board of Directors:

The SGMH Board of Directors is ultimately responsible for the safety and quality of care provided by the medical and hospital staff members. The Board reviews and approves the Performance Improvement and Patient Safety Plans and the Performance/Process Improvement Project Prioritization Grid on an annual basis.

The Board participates in the identification of priorities for improvement using the mission, vision, and values of the organization, strategic planning goals, the review of performance improvement reports and data provided by the performance improvement staff, industry and community standards and trends, regulatory agency standards, guidelines, rules & regulations, and other available resources as a basis for decision-making.

Medical Executive Committee/Quality Council:

The Board of Directors delegates the development, implementation, monitoring and evaluation of the Performance Improvement Plan to the SGMH Medical Executive Committee (MEC). The MEC is responsible for improving the quality and safety of clinical care and service provided by the hospital staff and its medical staff. The MEC utilizes the "Quality Council" to carry out part of this function. The Quality Council is a multi-disciplinary committee comprised of representatives of the governing board, medical staff, administration, performance improvement, risk management, and selected hospital directors as invited.

Administration and Management:

The Board also delegates the development, implementation, monitoring and evaluation of the P.I. Plan to the SGMH Administration and Management Team. The administration and management team are responsible for providing the time and financial resources needed to improve the operational quality of care, safety culture and services provided by SGMH and its staff.

Patient Safety/Performance Improvement Committee:

This hospital committee focuses on organization-wide patient safety and performance improvement monitoring and review activities including, but not limited to, department-specific performance and outcome measures designed to identify opportunities for improvement, patient satisfaction reports, multidisciplinary P.I. Team/ Task Force projects, staff perceptions of patient safety and error reporting, Core Measures Reports, Patient Safety Organization quality measures reports, Regulatory agency deficiencies & related action plans for correction, Compliance reports, adverse events, and gap analysis activities, failure mode effects analysis and root cause analysis assessments, EOC/hazardous surveillance reports, Provider-preventable conditions reports, etc. A Quarterly Summary report of the above activities is presented at the Medical Staff Quality Council, the Medical Executive Committee and the Governing Board meetings.

DESIGNING PROCESSES AND SERVICES:

When designing a new or modified process or service, SGMH will strive to assure that it is designed well. The following criteria are utilized to determine the effectiveness of design:

- The design is consistent with the Mission, Vision, Values and organizational objectives of SGMH.
- The design meets the needs of the individuals served, organization and medical staff, and key stakeholders.
- When clinical processes are involved, the design is sound and consistent with acceptable national and/or community standards of care.
- The design is consistent with sound business practice, and reflects stewardship of resources.
- The design, as appropriate, incorporates information about new technology and/or the performance of similar design(s) in other organizations.
- The design, as appropriate, incorporates information from other organizations about "failure modes" and the "occurrence of adverse events".
- The design incorporates the results of performance improvement activities.

ESTABLISHING PERFORMANCE MEASURES:

SGMH will establish measurements to monitor its performance and patient care outcomes. The scope of measurement will take into consideration, and be consistent with, the important care and services provided, and the critical functions of the organization.

Criteria:

The following criteria is used to determine the scope and prioritization of performance measurement and improvement:

- Assure the safety of the environment of care
- Assure the safety of the providers of care and the recipients of care
- Further the Mission and strategic objectives of SGMH
- Meet legal, regulatory, ~~licensure~~license and accreditation requirements
- Establish the effectiveness, timeliness, and stability of processes that are high-risk, high-volume or problem-prone
- Establish desirable outcomes of care for at-risk populations
- Determine the effectiveness of the design of new or modified services.

Scope of Performance Measurement:

Based on the application of the above criteria, the following care, services, and functions are monitored and/or measured:

- HEART Program Team Response to Adverse Events
- Bridge Program Management of Opioid Use
- Patient/Family Engagement Process
  ~~ED Throughput & Patient Safety~~
- **Patient Experience Multidisciplinary Committee**
- **Data Transparency (HQI Community Engagement)**
- Management of Sepsis Bundle
- C-Difficile Infection Monitoring
- Homeless Patient Discharge ~~Proces~~Process

- EMTALA Review
- Medical Screening Exams (OB & ED)
- Safety & Appropriateness of Tubing Connectors
- Risk Management/Error Prevention activities
- Utilization Review/Case Management/Discharge Planning & Social Services
- Core Measures
- Medication Error Reduction Program (MERP)
- Antibiotic Stewardship Program (Inpatient & Outpatient)
- Patient/Family Engagement Activities
- Organization-wide Culture of Safety
- Leadership Effectiveness in Establishing a Culture of Safety
- Quality Control Activities
- Staff Opinions and Education Needs
- Outcomes of Selected Processes or Services
- Autopsy Results
- BETA Healthcare Services
- Customer Satisfaction
- Control & Prevention of Infection
- Survey on Perceptions of Patient Safety & Reporting Errors in Healthcare
- Use of Medications
- Performance of Operative, Invasive and Non-Invasive Procedures that Place Patients at Risk (Inpatient & Outpatient)
- Use of Blood and Blood Components
- Use of Restraints
- Care and Service to High-Risk Populations
- Outcomes related to "Rapid Response Team" interventions and Cardio-Respiratory Resuscitation (Code Committee)
- Outcomes Related to the Use of Procedural Sedation
- Adverse Events/Significant Near Misses
- Patient Complaints/Grievance Process
- Federal & State Required Improvement Projects
- Hospital Improvement Collaboratives (CAL-HIIN, PRIME, HEART, TeamSTEPPS, etc.)
- Medi-Cal Provider Preventable Conditions
- Value-Based Purchasing Program
- Continuous Survey Readiness

Measurement of the above areas may be organization-wide in scope, targeted to specific areas, departments and services, or focused on selected populations. Measurement may also be ongoing, time-limiting, episodic, intensive, or recurring. The duration, intensity, and frequency of a particular performance measure are based on the needs of the organization, external requirements, and the result of data analysis.

Data Collection and Aggregation:

Collecting data is the foundation of performance improvement. You can't improve unless you've measured first (baseline).

Purpose:

The purpose of data collection is to:

- Establish a baseline level of performance
- Determine the stability of the process
- Determine the effectiveness of a process or desirability of an outcome as compared to internal or external targets (benchmarks)
- Identify opportunities for improvement
- Identify the need for more focused data collection
- Determine whether improvement has been achieved and/or sustained.

Structure:

Performance measures require structure to assure that data is appropriately identified, collected, aggregated, displayed, and analyzed. In general, this structure should consist of:

- A definition of the measure – including the dimensions of performance being measured
- The population to be measured (including, when appropriate, criteria for inclusion and/or exclusion
- The type of measurement (i.e. rate based or event based)
- The minimum sampling size to assure statistical validity
- The frequency of data collection/aggregation
- The methodology by which data will be collected
- The entity/individual(s) primarily responsible for data collection
- The manner in which aggregated data will be displayed
- The entity(s) to which the aggregated data will be reported to for analysis and action.

Assessment of Performance:

Data on performance measures will be analyzed to identify "opportunities for improvement". There are two (2) basic approaches utilized by SGMH to assess performance and/or outcomes:

Assessment of Aggregated Data:

Data on "rate based" performance measures are aggregated to determine patterns, trends, and variation (common or special cause). Data may be aggregated for a single point in time or over time, depending on the needs of the organization and the reason for monitoring the performance or outcome. In general, measurement designed to establish the desired stability of a process or desired outcome will be measured over time until target levels of performance are met. Once a process is considered stable, and/or a desired level of performance has been achieved, then an assessment of performance measures may be conducted in a more episodic fashion.

Data that is "event-based" is assessed in singular or aggregated form depending on the number of data elements in the performance measure. In general, event-based measurements are monitored on an ongoing basis.

Intensive Assessments:

Data will be intensively assessed when SGMH detects or suspects a significant undesirable performance or variation. Intense analysis is called for when:

- Levels of performance, patterns, or trends vary significantly and undesirably from those expected.
- Performance varies significantly and undesirably from that of other organizations or recognized standards.
- An adverse event has occurred.
- There is a confirmed hemolytic transfusion reaction.
- There is a significant medication error.

- There is a significant adverse drug reaction.
- There is a major discrepancy or pattern of discrepancy between preoperative and postoperative diagnosis – including those identified during pathologic review of specimens removed during surgical or invasive procedures.
- There is a significant adverse event associated with anesthesia.

IMPROVING PERFORMANCE:

Performance Improvement Model:

SGMH will undertake efforts to improve existing processes and outcomes, and then sustain the improved performance. The accomplish this, SGMH has adopted a performance improvement model – PDCA. This model is explained below:
P = **Plan** to Implement Action
D = **Do** Implement the Plan
C = **Check** the Results
A = **Act** on the Findings

"Rapid-Cycle PDCA" is utilized when there is a need for rapid action and improvement on a high-risk issue or concern. These performance improvement models are utilized – formally or informally – in improvement efforts throughout the organization.

Sustaining Performance:

SGMH also recognizes that in order for performance improvement to be sustained, key staff must be educated about redesign of processes or other changes that are being implemented. To that end, the following processes have been established:

- The results of performance and improvement activities are communicated, as appropriate, to the Medical Staff and hospital staff through their respective organizational structures.
- The Board of Directors receives regular reports on the organization's performance and improvement activities.
- The input of key staff is sought to identify problem-prone areas and opportunities for improvement.

Annual Evaluation:

On an annual basis, this plan will be evaluated to determine if any changes to the scope or content must be made. The SGMH Performance Improvement Director will facilitate this review. Any changes or recommendations will be forwarded to the Patient Safety/Performance Improvement Committee, the ~~Quality Council, the~~ Medical Executive Committee and the Board of Directors for review and approval.

Attachments:

Approval Signatures

Step Description	Approver	Date
Hospital Board of Directors	Bobbi Duffy: Executive Assistant	pending
Medical Executive Committee	Amelia Frazier: Director Medical Staff Services	01/2020
Performance Improvement Committee	Pat Ziegler: Director Performance Improvement	01/2020

Step Description	Approver	Date
Policy & Procedure Committee	Gayle Freude: Nursing Director Med/Surg	01/2020
	Pat Ziegler: Director Performance Improvement	01/2020

Origination:	*04/1994*
Approved:	*N/A*
Last Revised:	*12/2019*
Policy Area:	*Emergency Preparedness*
References:	

Civil Disturbance or Unrest

Purpose:

The purpose of this policy to provide San Gorgonio Memorial Hospital (SGMH) associates with a policy and procedures on how to respond to a potential civil disturbance or unrest situation.

Policy:

This policy has been developed to ensure the safety and security of all associate, patients, visitors, and others utilizing the facility in the event of a civil disturbance.

Procedure:

A. Depending on the situation, but in most cases the hospital will initiate either a complete or partial ~~lockdown~~lock down of the facility in the event a civil disturbance should occur.

B. The Security Department shall:

1. Secure the hospitals points of egress and monitor access into the Emergency Department (Triage and Treatment Areas).
2. Coordinate the screening of persons entering the hospital or other buildings in the affected area(s), as appropriate and per directions disseminated through the House Supervisor who will act as the Incident Commander or Hospital Command Center (HCC), if activated.

C. The Triage Unit Leader or designee will attempt to make every effort to ensure that those casualties who are affiliated with law enforcement agencies are kept separate from any service members who are being treated.

D. Should the civil disturbance occur in the immediate area of SGMH, additional actions that are required include:

1. Security
   a. Will contact the House Supervisor and Safety Officer to make a collaborative decision to initiate the lock down of the hospital (see lock down policy for additional information)
   b. Efforts should be coordinated with local law enforcement agencies via the Safety Officer who will act as the Liaison Officer.
   c. Permit local law enforcement officials to enforce laws and control crowd violence at SGMH, if required.

d. The following areas should be considered for enhanced security support:
    - Areas where there is violent for demonstrative behavior
    - Emergency Department main and ambulance entrances
    - Utilities control areas, such as the Central Utility Plant
    - Loading dock and Material Management storage areas
2. Restrict visitation to a minimum, for the safety of associates and patients.
3. Encourage patients to remain in their rooms, for safety reasons.

E. See Hospital Lock down Policy for additional information.

Attachments:

Approval Signatures

Step Description	Approver	Date
Hospital Board of Directors	Bobbi Duffy: Executive Assistant	pending
Policy & Procedure Committee	Gayle Freude: Nursing Director Med/Surg	01/2020
	Joey Hunter: Director Emergency Preparedness, EOC & Security	12/2019

SAN GORGONIO MEMORIAL HOSPITAL

Origination:	*03/1984*
Approved:	*N/A*
Last Revised:	*01/2020*
Policy Area:	*Security*
References:	

Code Gray - Combative Person

Purpose:

This policy has been developed to provide SGMH associates with an understanding of when a Code Gray should be initiated, as well as provide sufficient information in response to and management of assaultive or violent behavior.

Policy:

San Gorgonio Memorial Hospital (SGMH) commits to promoting workplace safety, prohibits threats and violence of any kind, and requires immediate reporting of any incident that causes a concern for safety, as well as requiring discipline, considering or carrying out criminal charges against anyone committing violence in the workplace.

Procedure:

Early Warning Signs/Response

A. No single sign alone should cause concern, but a combination of any of the following should be cause for concern and action.

1. Direct or verbal threats of harm.
2. Intimidation of others by words and/or actions.
3. Refusing to follow policy.
4. Carrying a concealed weapon or flashing a weapon to test reactions.
5. Hypersensitivity or extreme suspiciousness.
6. Extreme moral righteousness.
7. Inability to take criticism of job performance.
8. Holding a grudge,especially against supervisor.
9. Often verbalizing hope for something to happen to the 'other' person against whom the individual has the grudge.
10. Expression of extreme desperation over recent problems.
11. Destruction of property.

B. **Hospital associate**

1. When associates are concerned about their own safety and the safety of others due to abusive or assaultive behavior, they are to initiate a Code Gray ***when there is clear and present danger or the likelihood that violence will occur***.
2. If confronted by a verbally aggressive or violent and threatening subject, associates should initiate a "Code Gray" by pushing a panic button or use the phone to call 55 (Emergency Code Phone).
3. If panic button is activated, attempt to dial 55 as well to provide additional information to help identify the assaultive person and the location.
4. When calling the PBX operator move to a safe location to place the call.
5. If a weapon or hostage is involved follow procedures outlined in the Code Silver (Weapon/Hostage/Active Shooter) policy by telling the operator about the weapon, hostage or suspect if safe to do so.
6. Make mental notes or as quickly as possible write out notes to be used to pass on to a supervisor or security.
7. Do not attempt to disarm or physically restrain the assaultive or violent person. ***DO NOT PUT YOURSELF IN JEOPARDY OF BODILY HARM.***
8. Evacuation of the area may be necessary. All hospital associates should be aware of the evacuation routes posted in their departments.
9. Hospital associates not directly involved in the incident should avoid the area until the "All Clear" announcement is made.

C. **Security**

1. When a Code Gray is initiated, security will respond to the area to investigate the event and initiate an appropriate level of response.
2. Will approach with caution.
3. Evaluate the environment and subject(s) involved.
4. If necessary initiate or continue the evacuation of associates, patients and visitors.
5. With the assistance of the PBX operator request for law enforcement back-up if necessary by dialing 9-1-1.
6. Contact the House Supervisor.
7. Document the incident including any use of force by filing a Verge Incident report and completing a Daily Activity Report (D.A.R.).
8. Notify the PBX operator once the situation is under control so that the "All Clear" is announced.

D. **PBX/55 operator**

1. The PBX or 55 operator will contact security via 2-way radio or cell phone to inform security officers on duty of "Code Gray" and the location in case the security officers are in an area where the overhead page is not heard.
2. Upon request from security or house supervisor notify the local police department.
3. Upon request by Security/House Supervisor announce "All Clear" overhead three times.

E. **House Supervisor**

1. Attempt to ensure the safety of all involved in the Code Gray situation;
2. Call 9-1-1 immediately, if the situation does not seem to de-escalate;
3. Serve as an adjunct to the Security Officer in some situations, if required;
4. Inform the Administration on Call (AOC), Employee Health and the Safety Officer, if they are not on-site, especially if there has been any disruption of service, personal injury or potential workplace violence.
5. Ensure appropriate documentation and reporting of the incident, by completing a Verge report.
6. Ensure that the completed Code Gray Debriefing Form is submitted to the Safety Officer, to ensure appropriate follow-up.

F. **Education and Training**

1. All associates are required to have awareness level training in workplace violence. All SGMH associates receive appropriate training in workplace violence at new hire orientation and annually thereafter ~~as part of the hospitals Workplace Violence Prevention Program~~.
2. Associates working in the following departments must have (yearly) hands-on training and certification in workplace violence:
    a. Security
    b. Emergency Department
    c. Registration
    d. House Supervisors/ Sitters
    e. ICU/DOU
    f. Med Surg
    g. Respiratory Therapy
    h. Environmental Services (EVS)
    i. Float Pool
    j. Human Resources
    k. Radiology
3. Avade workplace violence training dates are posted throughout the facility and are also listed in the employee newsletter each year.

SGMH supports and promotes the Department of Homeland Security, if you see something suspicious, to say something. If any persons, behavior, etc. appears suspicious, immediately report it to Security by dialing (951) 392-7463 or ~~call~~dial 9-1-1.

Attachments:

Code Gray Debriefing Form

Approval Signatures

Step Description	Approver	Date
Hospital Board of Directors	Bobbi Duffy: Executive Assistant	pending
Policy & Procedure	Gayle Freude: Nursing Director Med/Surg	01/2020

Step Description	Approver	Date
Committee		
	Joey Hunter: Director Emergency Preparedness, EOC & Security	01/2020

Origination:	*03/2015*
Approved:	*N/A*
Last Revised:	*11/2019*
Policy Area:	*Case Management*
References:	*42 CFR 482.30, 42 CFR 482.43, Utilization Review & Califonia HSC Section 1262.5*

Discharge Planning Evaluation

~~Discharge Planning Evaluation/Discharge Plan Formation~~

~~Policies:~~

Policy:

Patients/Patient's Representative are entitled to a post-acute care needs evaluation by, or supervised by, a Registered Nurse or social worker, early in the stay taking into account patient/patient's representative preferences in the formulation of post-acute planning. ~~Other staff~~Staff members who may participate in the discharge plan are the Clerical Case Management Assistant ~~-Clerical and~~and Licensed Vocational Nurse (LVN) Case Management Assistant ~~- LVN -~~within their scope of practice and under the supervision of a registered nurse case manager or social worker.

Procedure:

The ~~valuation~~evaluation addresses, as appropriate to the patient's presentation, the likelihood of post-acute service needs and availability of those services. The evaluation is specific to the patient, centered on the individual's needs and expressed ~~goals~~preferences where needs for case management or social work intervention are identified. The plan, as much as is possible, conforms to the patient/patient's representative stated preferences and goals ~~and preference~~ of post-acute ~~service providers~~continuum of care.

~~The evaluation procedure, for purposes of continuity of work flow, reference activities of Utilization Review for level of care screening where the tasks occur concurrently.~~

~~Interview Process/Initial Plan Formation:~~

Interview Process/Initial Plan Formation:

1. Based on ~~your~~the case manager or social worker's knowledge of the typical recovery curve for the patient's diagnoses, and the nursing and physician admission written assessments, determine ~~if a~~what degree of patient interview is needed. ~~Do this concurrent to the initial InterQual level of~~Follow for a change of condition that may indicate a more thorough assessment of post-caute care ~~screening~~needs. ~~If no needs for Case Management intervention are identified, a note to that effect~~Included in the

assessment and plan is ~~entered into the medical record~~a review of previous hospital encounters. ~~Follow for a change of condition. Included in the assessment and plan is a review of previous hospital encounters - inpatient admissions, observation stays and ED visits.~~

2. During an interview:
    a. Ask the patient/patient representative what ~~she has~~they have been told to expect by ~~her~~their doctor, and what ~~she knows~~they know about ~~her~~their treatment~~.~~
    b. Ask what the patient/patient representative anticipates in terms of post-acute care, establishing preferences
    c. As indicated, ask about and document patient experience with a ~~DME~~medical equipment vendor, Home Health Care (HHC) agency or Skilled Nursing Facility (SNF) as indicated, and if he or she is established with a primary care provider or specialist~~.~~
    d. Ask about caregiver status if a caregiver is likely to be necessary. Include in the questioning the ability, willingness and availability of caregivers
    e. ~~Question the patient about her prior living arrangement; if indicated, ask about structural adaptations.~~Question the patient/patient representative about their prior living arrangement. identify with the patient the capacity of the prior living arrangement to meet their post-acute recovery goals and preferences
    f. Question the patient/patient representative about ~~her~~their prior level of function. Include adaptive equipment used ~~or possessed.~~and/or available to them
    g. Inquire regarding prior hospital encounters for the previous 6 months as applicable. Inquire as to why frequent encounters, such as readmissions, in their estimation were necessary. Share this information with the treatment team

        ~~Assess transportation situation, if can patient afford medications and need low-cost pharmacy information, require referral to a patient assistance program with a drug's manufacturer, or prior authorization assistance.~~
    h. Assess transportation situation
    i. Assess access to prescribed medications
    j. Confer with the patient/patient representative regarding ability for self-care and the ability to return to their prior living arrangement. Establish patient preferences
    k. Obtain express permission to engage in discharge planning, involving person(s) the patient/patient representative authorizes to be involved. Include guardian and conservator involvement, Physician Order for Life Sustaining Treatment (POLST) and Advance Directives

    ~~Communicate evaluation results with PT, OT, SLP, and RT if any or all are involved in care. If you have any questions not addressed to your satisfaction in the respective discipline's notes, ask questions. Document outcome.~~

    ~~Formulate an initial plan at the time of this evaluation. Outline the plan in the medical record including interventions intended to reduce readmission risk.~~
3. Communicate evaluation results with the treatment team
4. Consider the findings and goals established by the treatment team. As appropriate communicate these findings with the patient. Reassess with the patient their goals and preferences
5. Inform the physician of your findings, proposed plan and actions toward the plan. Review CM post-acute

plan with ~~other disciplines (including the nurse). Ask questions if any discipline's~~the treatment ~~plan is unclear. (For example: is this the IV anti-infective regimen for home, or are there likely changes once initial cultures are back; are oral meds likely instead; what are the short-term goals in PT.) Record the outcome of any discussion.~~team

6. Make contact with the post-acute providers as soon after the evaluation as possible. Begin the ~~transfer~~transition of care process, documenting steps taken toward ~~transfer of care~~goals and patient preferences. ~~The expectation is that complete post~~Post-acute care ~~arrangements~~transitions are initiated as early in the stay ~~and are complete prior to the physician's decision to discharge.~~as possible in concert with the treatment team findings and recommendations

   ~~Modify the Plan as the patient's recovery dictates.~~

   ~~Keep all concerned, especially the patient or representative(s) of changes and progress toward finalizing the plan.~~

~~Documentation:~~

1. ~~At a minimum, document the interview outcome including points a – g, above.~~
2. ~~The likelihood of the need for post-acute services and the ability to obtain those services. If physical rehabilitation is involved, assess rehabilitation potential and document (in concert with the interdisciplinary team).~~
3. ~~The patient's ability for self-care, the ability to return to her prior living arrangement, and as the information can be gathered, the ability, willingness and availability of caregivers.~~
4. ~~The giving of permission to engage in discharge planning, and other person(s) the patient authorizes to be involved.~~
5. ~~A summary of the interview's implications for the discharge plan.~~

Documentation:

1. Document discharge needs assessment according to department and hospital standards
2. Include patient/patient representative preferences, resources available including those available through insurance and community programs
3. Include barriers to health care self-management
4. Conclude with a strategy based on all the above

Special note on patient's right to refuse discharge planning interventions:

~~1.Patients or their legal representatives have a right to refuse care, or set limits on what care they will accept. This includes discharge planning and post-acute care arrangements. Refusals of CM services, or restrictions on planning activity must be documented in the medical record. Documentation includes any discussion of the adverse implications of refusal of care.~~

~~2. Because a refusal can be rescinded by the patient at any time, any information gathered that will contribute to formulating and executing a discharge plan is recorded and updated as necessary.~~

~~3. A patient may demand a plan that is of questionable safety or that cannot be accommodated with available resources. Document the specifics of the patient's proposal. Discuss the patient proposed discharge plan with the physician and members of the IDT, evaluating for ways to integrate the patient's concerns into a safe and feasible discharge plan. Return to the patient or representative with the modified plan for approval.~~

1. Patients or their legal representatives have a right to refuse care, or set limits on what care they will accept. This includes discharge planning. Refusals of Case Management (CM) services, or restrictions on planning activity must be documented in the medical record. Documentation includes any discussion of the adverse implications of refusal of care.
2. Because a refusal can be rescinded by the patient at any time, any information gathered that will contribute to formulating and executing a discharge plan is recorded and updated as necessary.
3. A patient/patient representative may demand a plan that is of questionable safety or that cannot be accommodated with available resources. Patient preferences must still be considered to the degree possible. Document the specifics of the patient's/patient's representative's proposal. Discuss the patient's/ patient's representative's proposed preferences and discharge plan with the physician and members of the treatment team, evaluating for ways to integrate the patient's/patient's representative's preferences into a safe and feasible discharge plan. Return to the patient or patient's representative with the modified plan.

Attachments:

2020 Conditions of Particiation changes - discharge planning

Approval Signatures

Step Description	Approver	Date
Hospital Board of Directors	Bobbi Duffy: Executive Assistant	pending
Medical Executive Committee	Amelia Frazier: Director Medical Staff Services	01/2020
Policy & Procedure Committtee	Gayle Freude: Nursing Director Med/Surg	12/2019
	Marvin Mitchell: Director Case Management	11/2019

SAN GORGONIO MEMORIAL HOSPITAL

Origination:	*01/2014*
Approved:	*N/A*
Last Revised:	*12/2019*
Policy Area:	*Dietary*
References:	

Dry Food Storage

Policy:

It is the policy of this facility to store food that is protected from contamination

~~Food Storage.~~

Procedure:

Food Storage:

1. Foods shall be protected from contamination by storing the food:
    1. In a clean, dry location;
    2. Where it is not exposed to splash, dust, or other contamination; and
    3. At least 12 inches above the floor
    4. No higher than 18 inches from the top
2. The dry storage area should be between 50 and 70 degrees.

~~Food may not be stored:~~

Food may not be stored:

1. In locker rooms;
2. In toilet rooms;
3. In dressing rooms;
4. In garbage rooms;
5. In mechanical rooms;
6. Under sewer lines that are not shielded to intercept potential drips;
7. Under leaking water lines, including leaking automatic fire sprinkler heads, or under lines on which water has condensed;
8. Under open stairwells; or
9. Under other sources of contamination.

Attachments:

Approval Signatures

Step Description	Approver	Date
Hospital Board of Directors	Bobbi Duffy: Executive Assistant	pending
Policy & Procedure Committee	Gayle Freude: Nursing Director Med/Surg	01/2020
	Jean Kielhold: Dietician	01/2020
	Lakeisha Hawthorne: Director Food and Nutrition	12/2019

SAN GORGONIO MEMORIAL HOSPITAL

Origination:	*06/2002*
Approved:	*N/A*
Last Revised:	*12/2016*
Policy Area:	*Dietary*
References:	

Liquid Puree Diet

Policy:

It is the policy of San Gorgonio Memorial Hospital to use liquid puree feedings if indicated by patient/resident's condition as assessed by the Speech Therapist or MD.

Procedure:

1. Liquified puree feeding of patients shall not be used for staff convenience.
2. An MD order is needed for this texture.
3. The Food Service Department will prepare this diet. These foods should be thinned with appropriate warm fluid to the consistency of thick cream soup. The portion size will be approximately 2 oz more per serving.

   Nursing is not to thin hot puree foods with cold liquids.
   Note:
   a. Blend food well to avoid lumps.
   b. Never thin puree food with water.
   c. Avoid excessive use of liquids to thin puree food items as this decreases nutrients.
   d. Never mix food items together. Patients/residents need to be able to taste foods individually.
4. Puree vegetables, fruits without thickener and soups are generally of appropriate consistency and need not be further thinned.
5. Dessert items such as custard, cobblers, etc. should be thinned to thick cream soup consistency with cold milk.
6. Bread is substituted with either thin cooked cereal or thinned starch.
7. Eggs served at breakfast must be altered. You may:
   a. Puree scrambled egg - thin with warmed milk.
8. Additional calories may be needed due to patient's inability to tolerate the volume of food in the liquified puree feedings. The dietitian will evaluate.
9. Liquified puree diets are inadequate in nutrients, notably iron, zinc and B vitamins. A multivitamin/mineral supplement is indicated.

10. Meat should be the first item fed.

Attachments:

Approval Signatures

Step Description	Approver	Date
Hospital Board of Directors	Bobbi Duffy: Executive Assistant	pending
Medical Executive Committee	Amelia Frazier: Director Medical Staff Services	01/2020
Policy & Procedure Committee	Gayle Freude: Nursing Director Med/Surg	12/2019
	Lakeisha Hawthorne: Director Food and Nutrition	11/2019

Origination:	*09/2015*
Approved:	*N/A*
Last Revised:	*12/2019*
Policy Area:	*Case Management*
References:	

Patient Choice of Post-Acute Skilled Services Providers

Policy

~~**Patient Choice of Providers**~~

Patients have the right to choose their providers of skilled services as part of the discharge/transitons of care~~. This extends to~~ planning: choice of Home Health Care (HHC), Hospice and Skilled Nursing Facility (SNF) providers. If transition to a ~~HHC agency or SNF~~skilled service provider is ordered, the case manager or social worker ~~involved in discharge planning~~ confers with the patient or designated decision maker to determine the patient's choice of provider. The Case Management/Social Work department maintains a current list of skilled services providers ~~of HHC and SNF services~~.

As of November 1, 2019 the patient or representative is also informed of quality and resource utilization data as found in the Medicare Nursing Home Compare, Home Heath Compare and Hospice Compare websites.

Procedure:

The HHC, SNF and Hospice list:

- Agency must be a Medicare provider
  ~~Agencies requesting to be on the list are included, unless they are not Medicare providers~~
- Agencies must be "available", meaning the agency serves the geographic area where patients will receive services. For practical purposes the list includes agencies covering Banning, Beaumont, Yucaipa, Calimesa, the Desert Cities, Cabazon, Hemet and San Jacinto areas, and the Morongo community
- The list includes providers known to be preferred providers of payers~~,~~ and medical groups ~~and medical staff, whether or not the agency has asked to be on the list~~
- ~~The list presented to a~~Guidance may be provided, tailored to the specific needs of the patient ~~may be tailored to the~~, such as specific ~~needs of the patient and limited to those within the geographic area where~~ services ~~will be rendered,~~offered (or not) physician preference ~~or~~and payer network considerations ~~(meet the Availability requirement)~~
  ~~Facilities with significant, published deficiencies such that case managers or social workers have concerns for a patient's safety may be temporarily removed from the list at the discretion of the Director for future reconsideration. Serious patient concerns brought to the attention of the Director or concerns expressed by medical staff may also result in temporary suspension from the list after investigation by the Director or designee.~~

~~Patients have the right to choose any provider, even if the patient will have to pay privately (as opposed to using a network provider). The choice to pay privately is presented as an option when selecting providers~~

- Include the Quality Measures information from the "Compare" websites. Interpretive guidance about the quality measures is allowed

~~The SNF list:~~

- ~~Facilities must be Medicare providers~~
- ~~Facilities located within the geographic service area of the hospital and surrounding communities are included (see HHC list considerations)~~
- ~~Facilities with significant, published deficiencies such that case managers or social workers have concerns for a patient's safety may be temporarily removed from the list at the discretion of the Director for future reconsideration. Serious patient concerns brought to the attention of the Director or concerns expressed by medical staff may also result in temporary suspension from the list after investigation by the Director or designee.~~
- ~~However, patients have the right to choose SNF providers despite any of the considerations, above.~~

Presenting Choices to Patient:

1. If ~~HHC or SNF~~skilled service transition of care is likely, the case manager or social worker, if not already completed during the initial discharge needs evaluation, asks the patient or designated decision maker if they have previous experience with an agency or facility, or have a preference of providers~~.~~
2. Patients or their designated decision makers have the right to choose any provider, even if the patient will have to pay privately (as opposed to using a network provider). The choice to pay privately is presented as an option when selecting providers
3. If the patient is already on service with a hospice, HHC agency, or is a resident of a SNF, the case manager asks if they may refer the patient back to that provider
4. ~~If the patient~~Only if permission is ~~already on service with a HHC agency, or is a resident of a SNF,~~given will the case manager ~~asks if they may refer the patient back to that provider. Only if permission is given will the case manager~~ or social worker begin the referral process~~.~~
5. If the patient or designated decision maker has ~~not~~ already ~~made a decision based on the information gather~~chosen a provider, ~~above,~~ the case manager or social worker ~~presents~~will still offer the list and quality data of available providers~~.~~
6. The case manager or social worker informs the patient or ~~surrogate~~designated decision maker that they have the right to choose from any available agency or facility. The patient's may choose a provider not on the hospital's list of available providers
7. The case manager or social worker advises the patient of those providers that offer any unique services necessary, as determined by the ordering physician
8. The case manager or social worker advises the patient or designated decision maker which providers are within the payer's network. If a patient chooses a non-network provider, the case manager ~~offers~~advises the patient or representative to contact the ~~provider for an estimate of charges~~payer for cost of out-of-network care
9. The social worker or case manager ~~also~~ advises the patient ~~of the following~~or designated decision maker of attending physician's or surgeon's preferences, if any. If the preference is based on treatment protocols which the HHC agency, hospice or SNF has adopted specifically to meet the physician's requirements, ~~the case manager explains~~ this is explained to the patient

10. ~~Asking for an alternate choice is generally advisable.~~Asking the patient or designated decision maker for alternate choices is generally advisable when their preferred provider is unable to provide services specific to the patient's needs
11. As much as possible, the case manager or social worker will honor the ~~wishes~~preferences of the patient or ~~authorized~~designated decision maker. If the patient's choice of providers is unavailable to ~~serve the patient by way geographic coverage, lack of services, or the inability to begin service within the time frame specified by the physician, the case manager or social worker is not obligated to follow~~meet the patient's ~~wishes~~specific needs or lacks the ability to begin service within the time frame specified by the physician, ~~but must return~~the case manager or social worker returns to the patient with an explanation and ~~to obtain~~obtains an alternate provider if one was not already identified

Attachments:

Approval Signatures

Step Description	Approver	Date
Hospital Board of Directors	Bobbi Duffy: Executive Assistant	pending
Medical Executive Committee	Amelia Frazier: Director Medical Staff Services	01/2020
Policy & Procedure Committtee	Gayle Freude: Nursing Director Med/Surg	01/2020
	Marvin Mitchell: Director Case Management	12/2019

Origination: *12/2017*
Approved: *N/A*
Last Revised: *01/2020*
Policy Area: *Nursing*
References: *CA Code of Regulations 70706.2*

Wound Debridement - Standardized Procedure

Policy:

San Gorgonio Memorial Hospital in order to provide a high standard of safe, appropriate, and effective care for patients requiring wound debridement utilizing different types of debridement of necrotic/ devitalized tissue on suitable patient.

Patient comfort and safety is optimized by:

- Completion of a patient assessment carried out by a certified wound care nurse/physician so most appropriate method of debridement is chosen.
- Offering ordered analgesia prior to debridement/dressing changes as needed.
- Obtaining the patient's consent and providing privacy during procedures.
- Acting within the accordance of universal precautions.

Scope of Practice:

Debridement methods such as autolytic, wound irrigations, wet-to-dry dressings, and enzymes are ideally initiated under the care of certified wound care nurses teaming with the physicians.

There are situations when more aggressive methods of debridement are required. Then choices may range from conservative sharps, caustic sticks, to maggot therapy.

A. Clinical indicators for wound debridement are:

- Chronic wound healing. Attempting to change the wound from chronic to acute inflammatory phase of wound healing.
- Wound bed preparation."Management of the wound to accelerate endogenous healing or to facilitate the effectiveness of other therapeutic measures"(Schultz et al.,2004)
  Wound bed preparation involves tissue management, inflammation and infection control, moisture balance and epithelial advancement of wound edges. Therefore, the debridement will influence bacterial load, pressure on tissues and influence the inflammatory phase of healing.

~~1. The presence of necrotic, devitalized tissue inhibits wound healing as it:~~

~~2. Hinders assessment of the degree of tissue damage.~~

~~3. Interferes with the granulation process.~~

~~4. Inhibits wound contraction.~~

5. ~~Obstructs epithelial cell migration.~~
6. ~~Promotes bacterial proliferation.~~
7. ~~May cause odor. (Carville 2005; Fraibarn, et al., 2002).~~

A. The presence of necrotic, devitalized tissue inhibits wound healing as it:
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   2. Interferes with the granulation process.
   3. Inhibits wound contraction.
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   5. Promotes bacterial proliferation.
   6. May cause odor. (Carville 2005; Fraibarn, et al., 2002).

II. Identification of Necrotic and Devitalized Tissue.

- Slough can be yellow, green, gray, or tan. This type of necrotic tissue is usually moist.
- Eschar is usually black necrotic tissue. Eschar appears as thick, leathery, black necrotic tissue that has dried out.

III. Cautions for Wound Debridement.

- Dry stable eschar/black necrotic tissue provides a natural barrier to infection. Therefore, the plan of care should be to avoid any trauma to the wound; this can be achieved by wrapping the area in a soft dressing and monitoring the patient for signs of infection.

There are some wounds in which wound debridement should be approached with relative caution due to the patient's underlying conditions. An assessment of the patient with the wound should identify any underlying condition that would effect wound healing.

- Conditions such as: diabetes, peripheral vascular disease, fungating and malignant wounds, ischemic heart disease.
- Pathological conditions such as: Thrombocytopenia Impaired liver function, Vitamin K deficiency.
- On long and short term anti-coagulation therapy, at risk of bleeding with impaired clotting mechanism and/or blood clot disorders. With an INR (International Normalized Ratio) greater than 3.0 in the past 24 hours. Patient with APTT (Activated Partial Thromboplastin Time) less than 24 seconds or PT (Partial Thromboplastin Time) less than 11 seconds.
- Non-steroidal anti-inflammatory therapy in use.
- Signs of infection are present, such as Erythema, Cellulitis (patient may require antibiotic therapy and/or antimicrobial dressings).
- Dry, stable eschar on the foot without signs of edema, erythema, or drainage (Ayello, Cardigan, & Kerstein, 2002). Ischemic ulcers that are covered with dry eschar should be referred to a Vascular Surgeon. In these cases oxygenation is insufficient to support infection control and wound healing, debridement is placing patient at risk for serious infectious complications (WOCN, 1996).
- With densely adherent necrotic tissue in which the interface between viable and nonviable tissue cannot be clearly identified (WOCN, 1996).

Procedure:

Methods of Debridement:

A full patient and wound assessment is essential to decide the wound bed preparation needed.

Each type of debridement has risks and/or benefits to the patient.

Autolytic Debridement:

The use of rehydrating or moisture retention dressings or agents to assist with lysis of necrotic tissues.

Advantages:

1. Selective debridement, not harmful to granulation or epithelialising tissue.
2. Inexpensive.

Disadvantages:

1. Result may be slow.
2. Risk of maceration to the surrounding tissue.
3. May increase wound drainage.
4. Can result in increase in odor.
5. Occlusive dressings are not recommended on anaerobically infected wounds

Method and products:

1. Hydrocolloids.
2. Hydrogels.
3. Alginates.

Biological Debridement:

See Biological (Maggot Therapy) Debridement Policy and Procedure.

Chemical Debridement:

The use of chemical agents for control or removal of necrotic,/devitalized tissue.

Advantages:

1. Bactericidal and bacteriostatic agents.

Disadvantages:

1. Chemical agents may be cytotoxic to healthy cells in wounds.
2. Some agents can be inactivated in the presence of pus or blood.

Methods and products:

1. Cadomexer Iodine.

2. Hypertonic saline impregnated dressing.
3. Caustic sticks. Contains silver nitrate (sometimes combined with potassium nitrate), and is used to cauterize skin. Note that when silver nitrate is applied to a wound, it dissolves and can spread to other locations where it can cause skin staining and tissue burns. Should this happen the area should be irrigated with copious amounts of water. Uses to include cauterizing of epiboly around the wound edge of a staled wound, necrotic tissue.May be a choice to treat hyper-granulation tissue in a wound.

Enzymatic Debridement:

Use of enzymatic agents to promote lysis of necrotic tissue, blood clots and fibrinous tissue.

Advantages:

1. May soften eschar.
2. Can be used in conjunction with conservative sharp debridement.

Disadvantages:

1. Expensive.
2. Relatively slow.
3. May macerate the skin surrounding the wound.

Methods and Products:

1. Enzymatic agent: Collagenase.

Mechanical Wound Debridement:

Is when an external force that is great enough to separate or break adhesive forces of necrotic tissue. Involves various methods including scrubbing, irrigation, whirlpool, and wet to dry dressings.

Advantages:

1. Quick method.

Disadvantages: Wet to dry:

1. Painful for patient to have dressing ripped off.
2. This method is non-selective it lifts away some viable tissue present in the wound.

Disadvantages : Water Whirlpool and high-pressure irrigation:

1. May result in Peri-wound maceration.
2. Water borne pathogens may cause infection or contamination of the wound bed.
3. Non-selective it may cause damage to viable tissues present in wound bed.

Conservative Sharp Wound Debridement (CSWD):

Conservative removal of loose, avascular, insensate tissue in a wound without pain or bleeding.

CSWD may be performed by clinicians, who are recognized by education, certificated, and by clinical competency. Nurses who specialize in wound care and have been certified, including Wound Ostomy and

Continuence Nurse (WOCN) or WCC.

Advantages:

1. Provides a fast and effective method of wound debridement.
2. Can be used when appropriate with other methods of debridement.
3. Remains less time consuming and less expensive.

Disadvantages:

1. Requires specialized and skilled clinician who is deemed clinically competent to perform this procedure (including anatomical knowledge).
2. Potential for increase pain for the patient.
3. Requires the maintenance of sterile, sharp instruments.

Wound care devices:

Sterile sharp scalpel; Sharp sterile scissors, iris or scissors with curved blades; Metal toothed sterile forceps; curettes.

Methods:

Performed at the bedside by certified clinical practitioner or physician.

Indications:

Extensive devitalized tissue; Cross hatching of eschar in preparation of enzymatic therapy; Adjunct in combination with other methods; Hyperkeratotic rim diabetic neurotrophic foot ulcers; Unstable eschar /heel ulcers.

Contraindications:

Bleeding disorders; Ischemic wounds; Severe arterial insufficiency; Dry gangrene; Malignant wounds; Unidentifiable structures ; Stable / Intact heel ulcers defined as firmly adherent to surrounding skin, no inflammation, no drainage, Eschar does not feel boggy or soft.

Surgical Debridement:

A definitive procedure performed by a Surgeon under anesthesia and aseptic conditions.

Advantages:

1. Fast and efficient.
2. Maximizes asepsis when performed in sterile working environment.
3. Appropriate when extensive necrosis or infection.
4. Prior to skin grafting.

Disadvantages:

Generally requires anesthetic with potential associated risk.

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Attachments:

Approval Signatures

Step Description	Approver	Date
Hospital Board	Bobbi Duffy: Executive Assistant	pending
Med Executive Committee	Amelia Frazier: Director Medical Staff Services	01/2020
Interdisciplinary Practice Committee	Amelia Frazier: Director Medical Staff Services	01/2020
Policy and Procedure	Gayle Freude: Nursing Director Med/Surg	01/2020
Nursing	Gayle Freude: Nursing Director Med/Surg	01/2020

TAB K

From: Quality Reporting Notification [mailto:qualityreportingnotification@hsag.com]
Sent: Wednesday, January 29, 2020 7:01 AM
Subject: Hospital Compare January 2020 Data Refresh

Hospital Compare (https://www.medicare.gov/hospitalcompare/search.html) reports information for over 4,000 hospitals nationwide, including Veterans Administration (VA) Medical Centers and Department of Defense (DoD) military hospitals. The website provides information for patients and caregivers on hospital care delivery and encourages hospitals to improve the quality of their care by publicly displaying quality information.

Users can compare performance across many common conditions. The Overall Hospital Quality Star Ratings summarize data from existing measures on *Hospital Compare* for each hospital to allow users to easily compare hospitals. With Data.Medicare.gov, users can explore and download hospital data, as well as data on ambulatory surgical centers, inpatient psychiatric facilities, and some cancer hospitals. The Centers for Medicare & Medicaid Services (CMS) updates the *Hospital Compare* website quarterly, though not all data are updated each quarter.

Data Updates

On January 29, 2020, CMS updated data on the *Hospital Compare* website and on Data.Medicare.gov.

CMS updated data for the following measures and measure groups:

- Overall Hospital Quality Star Rating (Note: Overall Hospital Ratings for January 2020 were calculated using measure data from the October 2019 *Hospital Compare* refresh and the February 2019 methodology. CMS made the decision to use October 2019 measure data to allow hospitals more time to preview results prior to publicly reporting the January 2020 Star Rating results.)
- Patient experience of care
    - Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey (includes data on Medicare-certified hospitals, VA medical centers, and Department of Defense hospitals)
    - Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems (OAS CAHPS) Survey for ambulatory surgical centers and hospital outpatient departments
- Timely and effective care
- Unplanned hospital visits (Note: CMS will be reporting two new measures: Admissions and Emergency Department [ED] Visits for Patients Receiving Outpatient Chemotherapy [OP-35] and Hospital Visits after Hospital Outpatient Surgery [OP-36].)

Beginning in January, CMS will no longer report the following measures on *Hospital Compare*:

- General Information (Both measures were removed in the FY 2019 Inpatient Prospective Payment System [IPPS] Final Rule: https://www.govinfo.gov/content/pkg/FR-2018-08-17/pdf/2018-16766.pdf.)
    - Inpatient Safe Surgery Checklist
    - Hospital Survey on Patient Survey Culture
- Timely and Effective Care (These measures were removed in the FY 2019 IPPS Final Rule: https://www.govinfo.gov/content/pkg/FR-2018-08-17/pdf/2018-16766.pdf.)
    - Average time patients spent in the emergency department, before they were admitted to the hospital as an inpatient
    - Patients assessed and given influenza vaccination
    - Patients who developed a blood clot while in the hospital who did not get treatment that could have prevented it
- Psychiatric Unit Services (These measures were removed in the FY 2019 Inpatient Psychiatric Facilities Prospective Payment System Final Rule: https://www.govinfo.gov/content/pkg/FR-2018-08-06/pdf/2018-16518.pdf.)
    - Type of system the facility typically uses to record and share patients' health information with other healthcare providers
    - Uses a health information service provider to securely share patients' health information with other healthcare providers at times of transitions in care
    - Asks patients about their healthcare experiences
    - Patients who were screened for alcohol abuse within the first day of their inpatient stay using a validated screening questionnaire
    - Patients who were screened for tobacco use within the first day of their inpatient stay
    - Healthcare workers given influenza vaccination
- Clinical Episode-Based Payment measures (removed in the FY2019 IPPS Final Rule: https://www.govinfo.gov/content/pkg/FR-2018-08-17/pdf/2018-16766.pdf)
- Hospital Outpatient Volume Data on Selected Outpatient Surgical Procedures (removed in the Calendar Year 2018 Outpatient Prospective Payment System Final Rule: https://www.govinfo.gov/content/pkg/FR-2017-12-14/pdf/R1-2017-23932.pdf)

CMS also updated data for the following quality reporting programs:

- Hospital Value-Based Purchasing Program
- Prospective Payment System-Exempt Cancer Hospital Quality Reporting Program
- Inpatient Psychiatric Facility Quality Reporting Program
- Ambulatory Surgical Center Quality Reporting Program

- Hospital-Acquired Condition Reduction Program
- Hospital Readmissions Reduction Program

CMS is also including data from the American College of Surgeons National Surgical Quality Improvement Program.

More Information and Other Compare Websites

For more information on *Hospital Compare*, please visit: https://www.medicare.gov/hospitalcompare/search.html.

For general questions regarding Hospital Public Reporting go to the *QualityNet* Question and Answer Tool.

CHHS
California Health & Human Services Agency

Hospital Quality Institute

Cal Hospital Compare

COPY

January 2020

Dear Hospital CEO,

The California Health and Human Services (CHHS) Agency, Hospital Quality Institute (HQI), and Cal Hospital Compare (CHC) are pleased to recognize your hospital with the **2019 Maternity Honor Roll Award.** The award signifies your hospital is delivering safer and more affordable care to Californians.

The CHHS Agency is committed to making California a healthy, vibrant, inclusive place to live, play, work, and learn. In support of this aim, the CHHS Agency endorses this honor roll in partnership with HQI and CHC. The HQI provides coordination and support for improvement and harmonizes measures for patient safety and quality improvement activities for the California Hospital Association, the Hospital Council, the Hospital Association of Southern California, and the Hospital Association of San Diego and Imperial Counties. CHC provides Californians with objective hospital performance ratings. To accelerate improvement and recognize high performance by California hospitals, CHC publishes three hospital honor rolls.

To receive this 2019 award, a California hospital must achieve a Cesarean section rate of 23.9 percent or lower for low-risk, first birth deliveries. The award is based on most recent data reported by California Maternal Quality Care Collaborative, Office of Statewide Health Planning and Development, and the California Department of Public Health-Vital Records.

To find out more about these honor rolls please check out Cal Hospital Compare's website at www.calhospitalcompare.org/programs/

Please extend our congratulations to all your hospital's physicians, nurses, other clinical staff, and administrators who have made this achievement possible. We also encourage you to share the news of your award with your patients and in your community.

Sincerely,

Mark Ghaly, MD
Secretary
CHHS Agency

Robert Imhoff
President
Hospital Quality Institute

Bruce Spurlock, MD
Executive Director
Cal Hospital Compare

CHHS
California Health & Human Services Agency

Hospital Quality Institute

Cal Hospital Compare

San Gorgonio Memorial Hospital

2019 Honor Roll Award

For Maternity Care

To receive this award, a California hospital must achieve a Cesarean section rate of 23.9 percent or lower for low-risk, first birth deliveries. The award is based on most recent data reported by California Maternal Quality Care Collaborative, Office of Statewide Health Planning and Development and the California Department of Public Health-Vital Records.

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Cal Hospital Compare

Survey examines the community's health needs, hospital to consider findings top priorities

BY DAVID JAMES HEISS
Record Gazette

Based on a comprehensive study, the Pass area needs to focus on prevention and management of chronic diseases, improve access to health services, and increase mental and behavioral health when it comes to dealing with substance abuse.

Those findings were recommendations based on the 2019 San Gorgonio Memorial Hospital Community Health Needs Assessment released at the end of 2019 in collaboration with Rancho Cucamonga-based HC2 Strategies, Inc. and Los Angeles-based Communities Lifting Communities.

The study analyzed metrics such as social and economic factors like poverty and educational attainment; health systems and access to health coverage; public health and prevention indicators such as cigarette smoking, diabetes and substance abuse rates; and physical environment.

Andrew Gardner, a member of the San Gorgonio Memorial Hospital's board of directors, says that the study "gives us the data needed to create and revise our long-term and short-term goals as we work with the community to service health needs and create a high level of quality care."

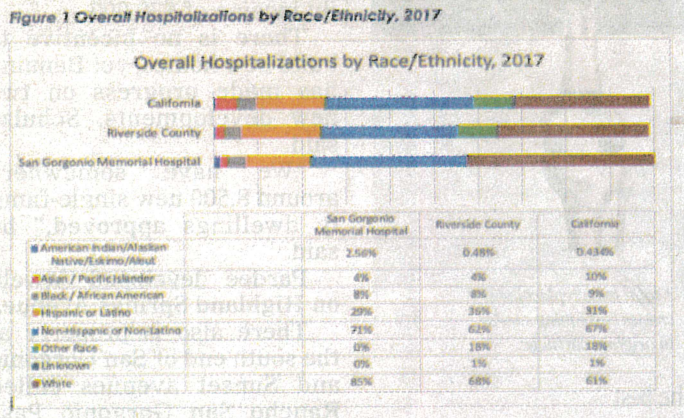
"The CHNA is very informative: it gives us invaluable information regarding not only the factual statistics of our primary service area, but also the weight of importance placed on health matters" by the hospital's constituents," Gardner says.

Clinical psychiatrist Joe Dunn had not had a chance to review the report, but helped craft mental health components of the study.

"Mental health is definitely a priority that can have a domino effect in the community," Dunn says. "When you're not dealing with mental health properly, there ends up a lot of visits to the emer-

(See SURVEY, page 9)

Figure 1 Overall Hospitalizations by Race/Ethnicity, 2017



	San Gorgonio Memorial Hospital	Riverside County	California
American Indian/Alaskan Native/Eskimo/Aleut	2.56%	0.48%	0.434%
Asian / Pacific Islander	4%	4%	10%
Black / African American	8%	8%	9%
Hispanic or Latino	29%	36%	31%
Non-Hispanic or Non-Latino	71%	62%	67%
Other Race	0%	18%	18%
Unknown	0%	1%	1%
White	85%	68%	61%

Data source: 2017 Hospitalizations derived from the OSHPD file using Speedtrack analytics platform.

SURVEY

(continued from page 1)

gency room, which may not be the most appropriate place to with those issues. Providing programs helps clients address physical needs, and gives them a place where they can be themselves and receive support in a structured program without losing their independence."

A few of the components from the study are outlined in this report.

Social and economic factors: employment, poverty and educational attainment

According to the study, for every 10,000 children within San Gorgonio Memorial Hospital's primary service area, there are a higher number of Head Start facilities compared to the rest of Riverside County; the averages for adults having less than a high school education is lower in this area at 15.8 percent compared to the county at 18.9 percent and the state at 17.5 percent; the hospital's service area enjoys a lower housing cost burden (paying more than 30 percent of income for housing) compared to 42.1 percent throughout the county and 44.6 percent around the state.

Key findings also show that the homeless count in the county was higher in 2019 at 2,811 unsheltered adults, compared to 2018's 2,316; and when it came to unintentional injuries, Riverside County had the highest rate of drug-induced deaths when adjusted by age per 100,000 at 16.4 compared to 12.7 in the rest state; and the county also witnessed a higher rate of motor vehicle accidents (age-adjusted) at 12 per 100,000 compared to 9.5 for the state.

When it comes to reading proficiency, 59.4 percent of fourth-graders scored "not proficient" or worse compared to 57 percent and 55 percent for the county and state. The report refers to a study by the Anne E. Casey Foundation that suggests "Children who do not read proficiently by the end of third grade are four times more likely to leave school without a diploma than a proficient reader."

Graduation rates within the hospital's service area were also lower than the county's and state's: 15.8 percent of those older than 25 who were surveyed did not have a high school diploma, compared to 18.9 percent for the county and 17.5 percent for the state.

The percentage of adults 25 and older who attained a bachelor's degree or higher in the hospital's service area was only 20.9 percent — slightly less than the county's 21.5 percent, and lower than the state's 32.6 percent.

Unemployment in the hospital's service area show that 11.4 percent of those between the ages of 16 to 19 are unemployed, compared to 8.9 percent in the county and 7 percent in the state.

"Addressing unemployment levels is important to community development" since such conditions "can lead to financial instability and serve as a barrier to healthcare access and utilization," particularly since many people secure healthcare through their employer, the report claims.

The Pass area's service region has a higher poverty level for children under 18 at 21.7 percent, compared to 21.3 percent in the county and 20.8 percent in the state.

The study notes that "Poverty is a particularly strong risk factor for disease and death, especially among children," citing claims by the National Center for Children in Poverty, which points out that "The single biggest threat to children's well-being is poverty. Poverty limits a child's ability to learn and contributes to poor health and mental health issues."

Further, 16.6 percent of the area's population is below the poverty level, compared to 15.6 percent for the county and 15.1 percent for the state.

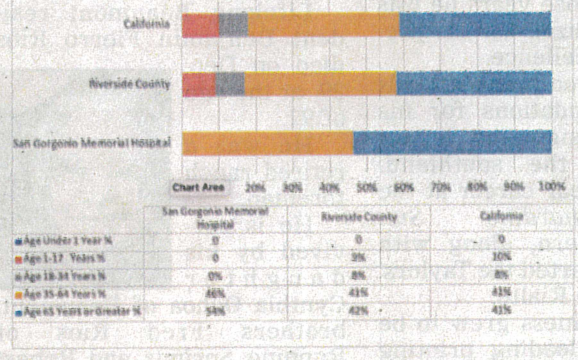
Photo by David James Heiss
Farmer's Market outside of the San Gorgonio Memorial Hospital.

Top 10 Leading Causes of Death (Age-Adjusted Rates per 100,000 Population)

Rank	Riverside County	California
1	All Cancers (141.1)	All Cancers (137.4)
2	Coronary Heart Disease (106.0)	Coronary Heart Disease (87.4)
3	Chronic Lower Respiratory Diseases (40.3)	Cerebrovascular Diseases (Stroke) (36.3)
4	Accidents - Unintentional Injuries (38.0)	Alzheimer's Disease (35.7)
5	Alzheimer's Disease (37.8)	Accidents - Unintentional Injuries (32.2)
6	Cerebrovascular Diseases (Stroke) (34.9)	Chronic Lower Respiratory Diseases (32.0)
7	Lung Cancer (27.3)	Lung Cancer (27.5)
8	Female Breast Cancer (21.1)	Diabetes (21.2)
9	Prostate Cancer (19.9)	Prostate Cancer (19.4)
10	Diabetes (19.1)	Female Breast Cancer (18.9)

Data Source: California Department of Public Health, County Health Status Profiles 2019, Individual County Data Sheets, 2015-2017 Death Files. Retrieved September 2019 from https://www.cdph.ca.gov/Programs/CHSI/Pages/Individual-County-Data-Sheets.aspx

Figure #3 All Cancer Hospitalizations by Age Group, 2017



	San Gorgonio Memorial Hospital	Riverside County	California
Age Under 1 Year %	0	0	0
Age 1-17 Years %	0	3%	10%
Age 18-34 Years %	0%	8%	8%
Age 35-64 Years %	46%	43%	43%
Age 65 Years or Greater %	54%	42%	41%

Data Source: 2017 Hospitalizations derived from the OSHPD file using Speedtrack analytics platform.

Key Findings

- Twenty-three percent of Hispanics and 85% of Whites are hospitalized for all cancers.
- Women (77%) have a significantly higher proportion of hospitalizations due to cancer compared to men (23%).
- Seniors age 65 years and older account for 54% of hospitalizations and adults age 35-64 years account for 46% of the hospitalizations for all cancers.

The county has a higher percentage of its population receiving Supplemental Nutritional Assistance Program benefits and Public Assistance Income: 12.3 percent of county residents receive SNAP benefits compared to 11.2 percent of others in the state, and 3.63 percent receive public assistance income or Temporary Assistance to Needy Families with 3.63 percent of county residents receiving such benefits compared to 3.58 percent for all of California.

The study highlights the fact that in 2014 Banning and Beaumont combined had the lowest count of violent crimes with 199 — the same year the county reported its lowest violent crime count of 6,260.

In 2018 Banning-Beaumont's share was 343 violent crimes and the county's was 7,360 (with a county peak in 2016 at 7,447).

The study concludes that, when it comes to social and economic well-being, "Hospitals and health systems are stepping outside of their traditional roles and beginning to collaboratively address social, economic and environmental conditions that contribute to poor health in the communities they serve."

Further, "Strategic multisectoral inverventions can help address the issues that have the greatest impact on people's health to move the dial on education and unemployment, helping to create a positive ripple effect on homelessness and unintentional injuries for the betterment of the community."

Health system accessibility: prenatal care, violence, uninsured and the homeless

The Community Health Needs Assessment starts out

(See SURVEY, page 14)

SURVEY

(continued from page 9)

its analysis of the health system started with examining prenatal care and outcomes following birth.

"Engaging in prenatal care decreases the likelihood of maternal and infant health risks," the report states. "These indicators can also highlight a lack of access to preventative care, a lack of health knowledge, insufficient provider outreach, and/or social barriers preventing care utilization of health care services."

A majority of the county's women received prenatal care in their first trimester — 83.5 percent — which is right in line with the state's average.

The study also identifies what it refers to women who received "adequate or adequate plus" prenatal care, referring to women who receive prenatal care by the fourth month of pregnancy, and 110 or more of recommended visits are achieved.

Teen births in the county are double that of the state's: 37.1 teens out of every 1,000 between 15 to 19 years-old gave birth, compared to 15.7 per 1,000 statewide.

The study depicts women in the county were slightly behind the state average when it comes to breastfeeding.

"Breastfeeding protects against diarrhea, common childhood illnesses such as pneumonia, and may have longer-term health benefits such as reducing the risk of overweight and obese children and adolescents," the study claims.

Its statistics report that 92.4 percent of women in the county initiated breast feeding, compared to 94 percent statewide.

Infant mortality rates are higher in Riverside County according to the study, with 5.3 deaths per 1,000 live births in the county compared to 4.4 per 1,000 statewide.

When it comes to access to healthcare — whether it was mental health, primary care, dentists, or health insurance — the county was behind.

In the county, there were 50.6 dentists per 100,000 residents compared to 83.4 in the state.

There were just 187.4 mental health care providers per 100,000 in the county, compared to 327.8 per 100,000 throughout the state.

And there were only 41.8 primary care physicians per 100,000 county residents compared to similar populations statewide, where there are 78.5 primary care physicians per 100,000.

In Riverside County 12.3 percent of the population was uninsured, compared to 8.9 percent of state residents, and 30.4 percent of the county's residents received Medi-Cal, compared to 27.3 percent statewide.

The hospital's service area has a higher number of community health centers and federally qualified health centers compared to the county and state.

San Gorgonio Memorial Hospital's primary service area boasts 3.99 federally qualified health centers per 100,000 residents compared to 2.01 countywide and 2.91 statewide.

There were 809,411 visits to emergency rooms in Riverside County in 2017; 47,158 of them were visits to the ER at San Gorgonio Memorial Hospital.

The hospital's highest percentages of visits based on diagnosis were essential (primary) hypertension at 14.53 percent; acute upper respiratory infection with 6.78 percent; urinary tract infections (5.82 percent) and type 2 diabetes mellitus without complications at 5.76 percent; and rounding out the top five was nicotine dependency at 5.49 percent.

Visits to emergency rooms by homeless individuals were higher in San Bernardino County than Riverside County: in San Bernardino County there were 1,117 visits in 2017 compared to 1,344 in Riverside County that year.

"Homelessness and health concerns often go hand-in-hand," the study states. "An acute behavioral health issues, such as an episode of psychosis, may lead to homelessness, and homelessness itself can exacerbate chronic medical conditions or lead to debilitating substance abuse problems," the report says.

The report points to a homeless count that was coordinated the morning of Jan. 29, 2019 by the Department of Public Social Services and the County of Riverside Continuum of Care network.

According to the numbers generated for that report, there were 2,821 sheltered and unsheltered homeless adults and children countywide, which was 21 percent higher than the count from the year before.

"This information is useful as it helps develop strategies to decrease homelessness and its associated health conditions with all community and county organizations involved," the study says.

The study showed that, at the start of 2019, there were 181 youth between 18-24 who were unsheltered in the county, and 83 who had a place to stay; there were 15 without shelter that were under 17, and 199 who had shelter; 131 unsheltered homeless youth did not provide ages.

Also under the guise of social and economic factors is a focus on violence and injury prevention.

Injury, according to the Centers for Disease Control and Prevention, is the leading cause of death for children and adults between the ages of 1-45 in the United States, which includes violence and unintentional injuries such as vehicular accidents.

"High rates of violent crimes can deter residents from pursuing healthy behaviors such as walking for leisure, or to and from work or school," the study states.

Included in that category is child abuse, of which the county surpasses state instances: in 2015, the last year data was compiled by the study, there were 8.4 cases per 1,000 children statewide as opposed to 9.6 cases per 1,000 kids countywide, based on figures from the Annie E. Casey Foundation.

Unintentional injuries per 100,000 in the county exceeded those of the state: 12 motor vehicle crash deaths per 100,000 in the county compared to 9.5 per 100,000 in the state; and 16.4 drug-induced deaths for the same numbers of victims in the county, compared to 12.7 deaths per 100,000 statewide.

According to the study, "When looking at violent crimes, between 2014-18, Banning-Beaumont saw the highest counts in 2018 and the lowest in 2014," while Riverside County as a whole saw its highest count in 2016 and its lowest in 2014.

"Rates of violent crimes in a community not only compromises individuals' real and perceived safety, but can be detrimental to overall mental health," the study says.

The study notes "Hospitals and health systems are stepping outside of their traditional roles and beginning to collaboratively address the social, economic and environmental conditions that contribute to poor health in the communities they serve," and various combined interventions "can help address the issues that have the greatest impact on people's health to move the dial on education and unemployment, helping to create a positive ripple effect on homelessness and unintentional injuries for the betterment of community."

Where analysis goes from here

The 125-page study is comprehensive, and can be viewed on San Gorgonio Memorial Hospital's website at sgmh.org/wp-content/uploads/2019/12/12.9_Draft_San-Gorgonio-2019-CHNA_R11.pdf .

The Record Gazette has provided insight into the first few components of the study.

Other areas of the study discuss topics such as mortality, mental health, sexually transmitted infections, hospitalization visits for cancer, asthma, heart disease, tobacco use and diabetes (within the San Gorgonio Memorial Hospital's service area, the city of Banning had the highest admissions for diabetes short-term complications and uncontrolled diabetes, whereas Cabazon had the highest admissions for hypertension and asthma in younger adults), according to key findings published in the study.

In light of the 2016 Community Health Needs

(See SURVEY, page 16)

SURVEY

(continued from page 14)

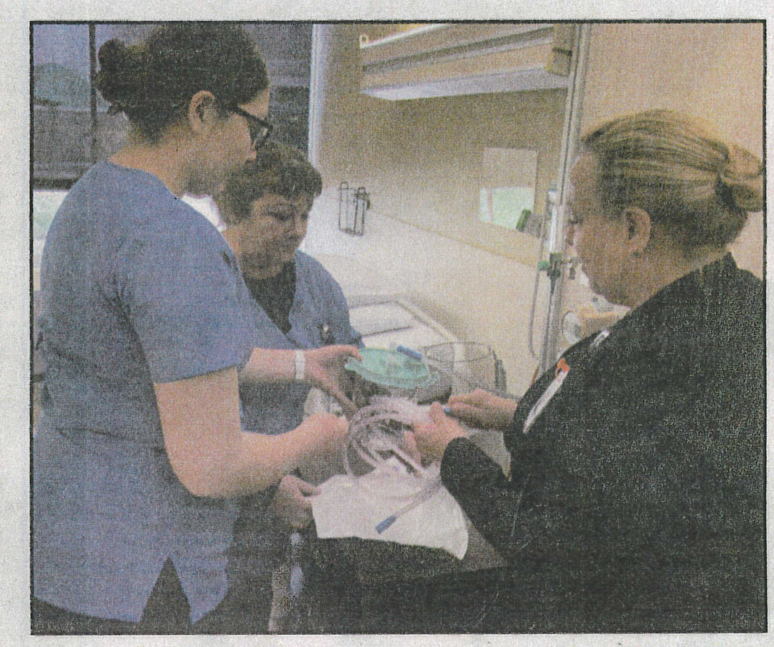
Assessment, the hospital strived to address priorities based on the critical issues identified three years earlier, which included tackling diabetes, obesity and healthcare workforce development.

To address those findings, the hospital offered free health and nutrition classes, weight management programs, introduced an organic farmer's market every Tuesday morning, and implemented healthier selections in its cafeteria.

As for the 2019 survey, "There's a lot of good information in this, but the most important part is putting together our action plan" says hospital CEO Steven Barron. "Next month during the board retreat we will work on the action plan" to determine how to tackle the top topics picked by the community, "and come up with ways we can partner with organizations to address these needs, since we can't do everything on our own, like for the homeless issue, for instance: we don't house people at the hospital, but because a lot of homeless people come through our hospital, we can help direct them to partners" who can assist them with their needs, Barron says.

According to Holly Yonemoto, chief business development officer for San Gorgonio Memorial Hospital, the hospital's board wants to focus on three specific health needs for its 2019 survey, including prevention and management of chronic diseases (including diabetes, obesity, asthma, heart disease, cancer and nutrition and physical activity); access to health services (affordability and insurance, transportation, and addressing the shortage of health care workers and specialty physicians); and mental and behavioral health (substance abuse) — which will be discussed at the February board retreat.

One person not satisfied with the study is hospital board member Lanny



Swerdlow, a registered nurse who was a point of contact for the study as a representative of the LGBTQ community, and also assisted the study's coordinators in getting in touch with the Morongo reservation to have a representative of the Native American population available as a point of reference for the study.

"It lacked certain information on certain demographics," Swerdlow said, referring specifically to the Native American and the gay and lesbian communities. "A lot of those details were omitted, but we only spent $40,000" on the study, which was "a pittance" Swerdlow acknowledged, when hospitals can spend upwards of $100,000 for the government-required assessments.

"The hospital has to be careful how it spends its money, and I understand that," Swerdlow says. "The information reported was good information, but in my opinion it was not detailed enough."

The study may be viewed on the hospital's website at sgmh.org/wp-content/uploads/2019/12/12.9_Draft_San-Gorgonio-2019-CHNA_R11.pdf .

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San Gorgonio Memorial Hospital
32 mins •

San Gorgonio Memorial Hospital was awarded the 2019 Honor Roll Award for Maternity Care in California. We are extremely proud of our physicians, nurses, hospital board members, and administrators who have made this achievement possible. Thank you for all that you do every day to continue to provide safe and high-quality healthcare.

http://bit.ly/sgmh012320

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Honor Roll Award For Maternity Care | San Gorgonio Memorial Hospital

San Gorgonio Memorial Hospital's CEO speaks at Good Morning Beaumont

BY JULIE FARREN
Record Gazette

Steve Barron knows a lot about San Gorgonio Memorial Hospital.

For the past two years, he has served as interim chief executive officer and in November, the hospital's board of directors approved him as their permanent CEO.

Barron spoke about the hospital and its projects at the Jan. 10 Good Morning Beaumont chamber breakfast.

Barron has spent 40 years in the industry and formerly was CEO of St. Bernardine Medical Center in San Bernardino.

Currently, there is new construction taking place at the hospital.

There is the new purchasing department.

Barron said that the hospital is raising money for a new CT scanner, which they hope to have operating in the next three years.

This will be the second CT scanner for the hospital.

Photo by Alvin Cruz of Party Vibe Photo Booth.
Steve Barron, CEO of San Gorgonio Memorial Hospital.

San Gorgonio also is working on a neurology/stroke center, Barron said.

"This is pretty important," he said. "With a stroke, you want to get it diagnosed in a short amount of time."

The hospital also plans to have state-of-the-art surgery beds, said Barron.

The outpatient department has continued to grow over the past decade.

Barron said that in the past decade, there has been an increase in the number of outpatient surgeries.

In 2009, there were less than 5,000 outpatient discharges.

Today, the hospital has seen 10,000 outpatient discharges.

Barron said that the hospital will not have to transfer patients to another hospital with this next year.

They can stay right there at San Gorgonio Memorial Hospital. San Gorgonio Memorial Hospital has an important place in the San Gorgonio Pass area.

"This community really needs this hospital," he said.