Palomar Pomerado Health
JOINT MEETING OF THE BOARD OF DIRECTORS & STRATEGIC PLANNING COMMITTEE
POM – CONFERENCE ROOM E
August 16, 2005

AGENDA ITEM	DISCUSSION	CONCLUSION/ACTION	FOLLOW-UP/ RESPONSIBLE PARTY
CALL TO ORDER	6:03 p.m.		
ESTABLISHMENT OF QUORUM	Dr. Larson, Michael Covert, Linda Greer, Ted Kleiter, Bruce Krider, Dr. Otoshi, Dr. Rivera, Dr. Tornambe, and Director Scofield. Also attending were Dr. Buringrud, Jim Flinn, Gustavo Friederichsen, Lorie Harmon, Bob Hemker, Andy Hoang, Marcia Jackson, Dr. Kanter, Dr. Kolins, Dr. Kung, Tina Pope, Mike Shanahan, Lorie Shoemaker, and Al Stehly. Guests: Dr. Ron Riner, Joe Hook, Craig McInroy, Tom Chessum, Eyal Perchik, Jerzey Wollak, Steve Yundt, Dennis McFadden, and Greg Palmer. Reporters included: Booyeon Lee, San Diego Union Tribune; Andrea Moss, North County Times; and Angela Holman, Today's Local News.		
NOTICE OF MEETING	The notice of meeting was mailed consistent with legal requirements.		
PUBLIC COMMENTS	There were no requests for public comments.		
MINUTES July 19, 2005		**MOTION:** Motion made by Dr. Rivera, seconded by Bruce Krider, and carried for approval as presented.	

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INFORMATION TECHNOLOGY UPDATE	Dr. Kanter presented a clinical information technology update, including where we were, what we did, where we are, where we're going, and where the government is taking us, and a review of the process that got PPH to this point. **Electronic Medical Records Provide/Ensure:** • Increased timeliness and coordination of care • Enhanced preventive care & expedite patient care • Cost control • Order legibility & minimized transcription errors • Streamline the order process • Reduce adverse drug reactions • Better use of current medical knowledge to enhance appropriateness of care • Ability to aggregate data for epidemiologic analysis • Integration with PACS: Digital Imaging (Picture Archival Communications Systems) • Off-site order-entry **PPH IT History** • Aging enterprise-wide vendor systems are approaching end of useful life cycle • Costly to maintain and operate • Low level of user satisfaction with many existing systems • Lack of advanced clinical and decision support tools • PPH has under-invested in newer and easier to use software products in recent years		

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	IT Steering Committee • Determine long-range I/T objectives that support strategic business goals • Establish priorities for PPH-wide systems based on costs, benefits and financial feasibility • Decide appropriate and cost-effective I/T approaches • Authorize the necessary capital and labor resources needed to successfully implement the I/T strategies and projects • Approve a PPH-wide I/T Plan with technology standards and guidelines • Approve common standards and processes for systems selection and implementation **Overview of Objectives** • Identify key information needs to support an enterprise-wide information environment • Financial and administrative requirements • Patient care requirements • Clinical and financial decision support requirements • Determine adequacy of current Information Technology (I/T), staffing and organizational structure • Identify high-priority I/T projects • Determine cost-effective I/T acquisition and implementation approaches • Develop I/T organizational structure • Define I/T capital project budget • Establish implementation schedule - phased approach		

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	Information Technology Strategic Principles • Evaluate and select vendors on an enterprise-wide basis to facilitate integration and management of I/T within PPH • Acquisition of new information technology will focus on patient centered care and strengthening the financial viability of PPH entities • Investing in needed training and I/T support personnel **Process** • Organize project team and work plan • Determine detailed information system needs • RFP to nine major vendors –Siemens, IDX, Cerner, Meditech, McKesson, Eclypsis, Per-Se, Quadramed • Proposal evaluations – ideally, down to 3-4 systems/vendors • On-site demonstration by vendors – down to 3 vendors (Cerner, IDX, Siemens) • Site visits – final system • Contract negotiations • System implementation **Cerner Modules** **Phase I – *the foundation (completed items)*** • Lab (GL, AP, Micro, BB) • Radiology • Pharmacy • ED & OR • Registration & scheduling • Nurse charting • Master patient index, patient accounting, and		

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	medical records • Clinical data repository • Order & documentation management • Adverse drug event alerts • Ad-hoc report writer • Electronic Medication Administration Record (EMAR) **Other Cerner Applications** • PACS: Digital images (radiology) available 24/7 embedded within PowerChart – all up and running **Non-Cerner Clinical Applications** • Quickchart: 24/7 web based access to all transcribed documents (admit, discharge, consults, OP reports), labs, EKGs within or without PPH, all up and running. • Electronic Signature Authorization (ESA): able to electronically sign all transcribed documents through a secure web site 24/7 also without regard to location **Phase II** • Computerized Physician Order Entry (CPOE) • Intensive care management • SurgiNet materials management (might be removed from scope) • Retail pharmacy management • Anesthesia management • Document imaging • Medical transcription (phasing out softmed/ESA and Quickchart) • Cardiology management • Additional interfaces		

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	What is Computerized Physician Order Entry? • CPOE is a clinical software application designed specifically for use by physicians to write patient orders electronically rather than on paper. • CPOE is one part of an electronic medical record • Multiple different approaches to solving this issue • CPOE can reduce the incidence of serious medication errors by nearly 90% • CPOE reduced prescription costs by 30% at Royal Victoria Hospital (Montreal) – Improved efficiency, dosage, intervals, guidelines **A Harvard Medical School research study indicates the following regarding medication errors:** • 56% at time of ordering • 34% at administration • 6% at transcribing • 4% at dispensing **American Hospital Association** **Potential Benefits of CPOE include:** • Improved patient safety • Increased timeliness of care • Better use of current medical knowledge to enhance appropriateness of care • Better coordination of care • Fewer missed opportunities for preventive care • Ability to aggregate data for epidemiologic analysis • Control of costs		

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	Additional Clinical Efforts
	• Anesthesia: Docusys
	• Enterprise bar coding
	  o Blood bank
	  o Specimen handling
	  o Medication administration
	
	What's Next?
	• Upgrade to the most current version of the operating system (CERNER): **Done**
	• Upgrade our Oracle database: **In Progress**
	• Upgrade to Cerner's most current operating version (2005 v.2)
	• Regression testing (multiple months) to assure critical functionality
	• Plan, design, test, and roll out Phase 2 projects (2006 and forward)
	
	Our Goals
	• Recognize that CPOE is part of the larger enterprise objective to achieve the highest levels of safety, quality, and reliability…and that CPOE is not the only answer.
	• Provide all caregivers with the tools necessary to make this happen
	• Provide a tool set that can change and evolve in order to meet future needs including facilities expansion
	
	Dr. Kanter noted that Phase 2 of the IT Implementation will require more physician involvement. Dr. Kanter emphasized that telemedicine can put out a record when patient health declines, and monitoring can save lives.		

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	Dr. Larson asked what Dr. Kanter sees as the milestones for the next 12 months, and what are the #1 and #2 challenges. Dr. Kanter responded that, in the next 12 months, he wants to complete the legwork, and emphasized that PMC & POM have to be physically restructured before PPH can have the EMR system implemented. As far as challenges, Dr. Kanter replied that he views that there will be trouble with: 1) lack of good robust back-up disaster preparedness; and 2) taking more scheduled down time – he would like to see the system operating at 99%, with 1 planned down time per month. Ted Kleiter said that he is impressed by Dr. Kanter's commitment to this project. Director Scofield asked when CPOE would be available in the hospitals, and when it would be available for physicians. Dr. Kanter replied that it is available now for those who have access to internet explorer, but the doctor's note are not available yet. Michael Covert stressed that the CPOE system will change the nature of how medicine is practiced in non-traditional settings. Physicians can access the system from home or from their offices. Michael congratulated Dr. Kanter in his work on PPH Information Technology, and said that Dr. Kanter is the driver of this project, and deserves special recognition; he has certainly made a great difference to PPH. Dr. Larson asked if PPH has spent the budgeted $22 million for IT yet, and Bob Hemker responded that we have spent roughly $16 to $18 million, and we will continue to spend from CIP budgets to hard assets; we are still in the ballpark with equipment and operating costs.		

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ALL FACILITIES UPDATE (PMC EAST AND WEST, POM, AND SATELLITE OFFICES)	Since the July 19 Strategic Planning Committee meeting was also a Joint BOD/Strategic Planning Committee meeting, a partial update on the planning and process status of affected PPH Facilities (PMC East and West, and POM) was provided. Due to time constraints, the rest of the presentation was deferred until the August 16 Full BOD/Strategic Planning Committee meeting. Tonight's agenda includes: • Planning for Innovation • Evolving Design Concepts for Palomar West • Pomerado Hospital o Refocusing the campus o Architectural form development Steve Yundt and Craig McInroy presented the **PLANNING FOR INNOVATION** segment, summarized as follows: **Status** • Just completed initial phase of design • Focus on space planning (approximately 1.3 million SF (square feet) • Collective effort of Expansion Steering Committee, Champion Teams, and User Groups who have identified several areas where innovation is starting to occur • Certain aspects of the innovation can be viewed as leading edge – nationally **Objectives – To Develop** • Safest hospital for patients & staff o Fewest errors o Lowest infection rates o Best outcomes		

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	• Highest patient & staff satisfaction
	• Most efficient & cost-effective operations
	• Most environmentally sustainable facilities & operations (healing environment, etc.)
	• Flexibility to accept the future's technology & practice
	
	Program Allocation – "Lowest cost setting"
	• Allocation on a macro level
	• Four major programs:
	  o Central warehouse (now at Innovation)
	  o Central kitchen (room service concept)
	  o Data center (regional)
	  o Central laboratory – core lab, non-stat tests
	
	PATIENT CARE
	• Approximately 50% of total area should be for patient care
	• Ambitious program with broad service lines
	
	Patient Care – Private/Adaptable Room
	• Designed to allow 3-sided and 4-sided care, suitable for adaptations and changes
	• Space for distributed work & supply areas
	• Improved access to and visibility of the patient
	• Dedicated zones within the room (staff, PT, etc.)
	• Large window to the outside (connection to nature)
	• Wide door into the bathroom
	• Mock-up in progress
	
	Patient Care – Environment
	• Non-institutional design
	• Convertibility of room/utility configuration		

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	• Connection to nature; bring daylight to patient & staff **Patient Care – Distributed Nursing** • Improved observation of patient in room – reduces patient falls, increases patient satisfaction/safety • Reduced "hunting & gathering" – shorter walking distances to bedside • Supports multiple staffing ratios • Allows nurses to be closer to patients **Patient Care – Acuity Adaptable Floor** • Discussed 10-, 30-, 60-, 120-, and 240-bed modules and their program allocations, for the maximum, ultimate adaptability **PLANNING FOR INNOVATION – DIAGNOSTIC & TREATMENT** **Structure/Mechanical** • Rapidly changing technology • Unencumbered "loft" space **Environment** • Daylight, views, connection to nature • Seen in European hospitals, but not many in U.S. **Circulation** • Separate patient/staff circulation, keep traffic separate • Dedicated public circulation core & spine **Modularization/Flexibility /Expansion** • Modular planning • Grouping of "soft" spaces allows for future		

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	expansion – offices, conference rooms **Emergency Services & Imaging** • Universally sized treatment positions • Modules designed to accommodate fluctuations in volume and capacity; clusters for general treatment, all rooms same size • Separate inpatient & outpatient access to imaging • Creation of portals/suites for each imaging function **Interventional Platform** • Common floor for all invasive services for interdisciplinary activities • Increased flexibility – surgery, interventional radiology • Promotes interaction among specialists (erosion of "kingdoms") • Staffing efficiencies **WOMEN'S & CHILDREN'S CENTER** **Identity/Image** • Need strong identity • Peds separate but attached **Environment** • Garden setting, ground level or rooftop terrace • Connection to nature **NICU** • Easy to locate patient • No noise; privacy for patients and families		

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	• Private and semi-private rooms • Better control, proven results **ADMINISTRATION/OUTPATIENT** **Both Palomar West and Pomerado Hospital need:** • Combination of cellular and open plan offices • Shared central support spine • 3-sided exposure to daylight, nature & views • Flexibility to accommodate fluctuations in departmental requirements • Offices on perimeter • Common conference rooms, workrooms **Environment** • Garden setting, connection to nature **Next Steps** • Continue to refine program and skeleton plans • Start room mock-up process; ready for first phase • Start integration & overlay of technologies, medical equipment • Start discussions with OSHPD and Dept. of Health Services **EVOLVING DESIGN CONCEPTS – Summaries of architectural styles** Dennis McFadden from Anshen + Allen reviewed the history of architectural design, from classical architecture from the Greeks and Romans, to current architecture in the digital age. Discussion ensued about which design aspects will be		

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	implemented, considering that certain trends will have passed by the time the hospital is built. In order to avoid this, we will use all ages and eras in the planning and construction of the new Palomar West, using different aspects of each. We will also incorporate a quadrant approach, involving one or more central garden axis, with a central court, and a floor court. A central atrium will provide gardens on each floor, with double-height openness. Dr. Larson thanked Anshen + Allen & PPH management for a great, exciting presentation. Director Scofield wanted to know how we will be factoring in ADA (handicapped) regulations and requirements, and Tom Chessum responded that the site plan is still up in the air; we have plans, but the issue is parking plans, and Michael Covert said that we will be discussing these details during Innovation Week (August 15 – 19). **POMERADO HOSPITAL** **Refocusing the Campus** • New heart of campus, with new patient tower as a focal point, with a healing garden **Architectural Form Development** • Key issues – balancing conflicting needs: o Innovation – comfort of familiarity o New Image – respect for existing campus o Community Access – patient privacy • Site considerations - massing (how it is composed), layering facades, stepping the building back		

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	• Relationship to the campus – fenestration – continuity of window recesses, larger windows, more glass, exterior wall design • New image – sun protection, iconic forms **<u>Architectural Style Options</u>** • Iconic – new, exciting look, different from normal; most hospitals do not have this style of building o Special look such as tent-like canopy over the Women's Center o Meditation room o Sculptural staircases o Pockets of air under canopies o Solar design Dr. Rivera complimented the architects on a great presentation, and was glad to see everything in its entirety. Dr. Rivera met with the Escondido City Council, who would like to have portions of the new hospital on different areas. The Escondido City Council does not understand that patients cannot be seen at fragmented locations. He stressed that we have a once-in-a-lifetime opportunity, and we won't compromise our vision for political feasibility.		
COMMITTEE COMMENTS, SUGGESTIONS			
FINAL ADJOURNMENT	7:50 p.m.		

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SIGNATURES Committee Chairperson Recording Secretary	_____ Marcelo Rivera, M.D., Alan Larson, M.D. _____ Lorie Harmon		