Southern Mono Healthcare District
Report to the Board of Directors
Director of Quality Report
July 19, 2018

2017 Press Ganey Guardian of Excellence Award Winner
2017 Hospital Quality Institute Award Winner

DATE: **July 19, 2018**

TO: **Board of Directors**
Southern Mono Healthcare District

FROM: **Mike Rudolf, Director of Quality**

RE: **Community Health Needs Assessment Report, Regular Meeting of the Board of Directors**

Executive Summary

New Business

1. **Mammoth Hospital Community Health Needs Assessment (CHNA) Annual Report**
    1. **Access To Care**
    2. **Substance Abuse**
    3. **Behavioral Health**
    4. **Chronic Disease**

MAMMOTH HOSPITAL COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) ANNUAL REPORT

BACKGROUND: In preparing for the CHNA, individuals who represented the interests of the community and/or had specific expertise regarding the health needs of vulnerable and underserved populations were asked to join the CHNA Steering Committee to identify priority community health needs. Five criteria were used for prioritization: 'Magnitude/scale of the problem'; 'Severity of the problem'; 'Health disparities'; 'Community assets'; 'Ability to leverage' to arrive at four significant health needs to be addressed: 1. Access To Care; 2. Substance Abuse (Drug, ETOH, Tobacco); 3. Behavioral Health; 4. Chronic Disease (Obesity).

In compiling this annual report, our approach centered on the following:

- **A focus on mission, vision and values** as the foundation for integrating key performance and operational requirements within a results-oriented framework that creates a basis for action, feedback, and ongoing success.
    - **Our Mission**: To promote the well-being and improve the health of our residents and guests.
    - **Our Vision**: Meticulous Care - Memorable People - Majestic Location
    - **Our Values**:
        - Excellence - We will provide an experience that surpasses all expectations.
        - Leadership - We believe that effective leadership begins with a commitment to serve others.
        - Empathy - We will look through the lens of others without judgement.
        - Value - We will provide worth that pleases and surprises.
        - Accountability - We will honor and fulfill our agreements and promises.
        - Trust - We will cherish and respect the privilege and responsibility of our calling to serve others.
        - Encouragement - We will inspire courage and confidence to overcome adversity and enable healing.

- **A focus on processes** to assess and improve our processes along four dimensions:
    1. *Approach:* designing and selecting effective processes, methods, and measures.
    2. *Deployment:* implementing our approach consistently across our health care organization.
    3. *Learning:* assessing our progress and capturing new knowledge, including looking for opportunities for improvement and innovation.
    4. *Integration*: aligning our approach with our health care organization's needs; ensuring that our measures, information, and improvement systems complement each other across processes and work units; and harmonizing processes and operations across our health care organization to achieve key organization-wide goals.

- **A focus on results** leading us to examine our results from three viewpoints: the external view (*How do our patients, our community, and other stakeholders view us?*), the internal view (*How efficient and effective are our operations?*), and the future view (*Is our organization learning and growing?*).
    - *Future View*: While the CHNA steering committee will continue to have oversight, we will be merging our four CHNA implementation teams into already established hospital committees to better meet our goals. These committees include Population Health, Chronic Disease Management, Patient and Family Advisory Council, and Patient Experience and will act to operationalize the goals moving forward.

ACCESS TO CARE GOAL

Increase access to our healthcare services. This goal employs five strategies that involve enhanced collaboration among Mono County agencies, providing community education regarding our health care services and availability of financial assistance and the evaluation of additional services and their potential impact on access. Five strategies:

1. Facilitate collaboration among agencies within Mono County.
2. Mammoth Hospital will work with community service organizations to develop a collaborative framework designed to improve access to services through education.
3. Mammoth Hospital will provide community education regarding the availability of financial counseling / assistance.
4. Develop a media campaign describing the health care services available within the service area.
5. Evaluate the effectiveness of the addition of providers in urology, pediatrics, and family practice and their effect on access.

PATIENT-FOCUSED PROCESS RESULTS

- Two areas of ongoing collaboration, one with Mono County Public Health and the Mono County Office of Education and the other with Mono County Behavioral Health. We recently initiated the Mono County Vision Services Task Force to investigate ways to improve access to vision services for the underinsured population within Mono County. The second area of collaboration has been with Mono County Behavioral Health to attract a full-time psychiatrist to the region and to provide consultation in our Emergency Department with psychiatric emergency physicians via telemedicine. Mammoth Hospital recently extended an offer to a full-time physician as a result of this effort and we are awaiting his response. The emergency department utilizes California Emergency Physicians as their telemedicine consultant for psychiatric patients and this is reportedly working well despite its low volume.

- Approved by the Board of Directors last March 2017, we are in year two of the five-year Scope of Services Plan. There continues to be strong consensus from Medical Executive Committee (MEC) in expanding our visiting specialist model to include additional specialties such as Neurology, Endocrinology, Infectious Disease, Ophthalmology, Psychiatry, Pain Management, Adult Dental, and others such as the Tele-Medicine services cited below.

- Seeking to align our strategic plan with this CHNA, as reported on last year, we continue to pursue offering Tele-Psychiatry for both our outpatient and emergency services. The outpatient agreement with UC San Diego through our Clinic was mutually dissolved owing to our inability to bill their services under our RHC and their unwillingness to bill it themselves. The agreement with UC Davis for Tele-Medicine services to our Pediatricians in the areas of Endocrinology and Gastroenterology is working out well as UC Davis agreed to do their own physician billing for their consultations. Note: Their Tele-Medicine service is well funded by rural outreach grants.

- California Emergency Physicians (CEP's) continues to provide emergency tele-psych consults to our Emergency Department which will be paid for by Mono County Behavioral Health. While this program is low-volume, it is working well and is cost-effective. To date, we have avoided at least one transfer of a presumed 51/50 patient due to CEP's intervention.

- Last October, we added an additional surgeon Dr. Sarah Sindell who joined Dr. Fru Bahiraei and Dr. Rich Koehler in a full-time general surgery practice. We have seen an increase in volume with respect to ER visits, clinic visits, and the number of patients requiring admission to the hospital. In fact, over the last 10 years, our business model has completely changed. Once upon a time ago, surgery at Mammoth hospital was 80% emergent, and 20% elective. Today, those numbers ae completely reversed, with 80% of surgery cases being elective and 20% being emergent. In addition to any and all emergency needs that may arise, the Mammoth Hospital General Surgery group is able to provide a wide range of elective surgical services.

- Continue to evaluate the effectiveness of the addition of providers in urology, pediatrics, and family practice and their effect on access. The impact of additional providers in the specialties listed above is seen in the Statistical Management Report published monthly by the Finance Department. Family Practice visits were 17,118 year to date as compared with last year's 15,293. Pediatrics leveled off at 5,091 visits, down from the same period last year of 5,249. The drop was likely due to the lower provider availability from maternity leaves.

- New Patient Portal: On October 16, 2017, the hospital replaced multiple outdated electronic health records with a brand new system-wide electronic health record, Cerner Community Works. This system is used in every department in the hospital, from the Emergency Room to the Clinics to the Inpatient Ward to the Operating Room to the Lab to the Radiology Department. So when you go to a clinic appointment after having been seen in the Emergency Room one week earlier, your doctor has access not only to the record of that visit, but to every visit you have had in the Mammoth Hospital health system. This makes it much easier to take into account all of the aspects of your medical condition, and make a more comprehensive plan of how to best care for you. Something else that is new since our go-live date in October is our patient portal. By signing up for the portal, you have instant access to your medical record, including clinic visit summaries, lab results, x-ray results, your medication list, and your medical problem list. Additionally, you can send messages to your provider, request refills of your medications, and request appointments. Also, there is a robust medical library included in the portal, where you can find resources on virtually every medical condition, watch instructional videos, or learn how a knee replacement is performed. Finally, with the phone app you can download on your smartphone, your record is portable, and goes where you go.

- Last fall, we received a $10,000 Vons Foundation Grant to fund Local Mammography. This was the fifth year that Mammoth Hospital and Vons have collaborated for the cause. All donations will help underprivileged women of Mono County and surrounding communities pay for mammograms as part of Mammoth Hospital's continued promise to make early breast cancer detection and treatment available to all area residents. Coming late 2018, the hospital will purchase a new 3D Mammography Tomosynthesis machine which is the latest advancement in the battle against breast cancer. "It captures a three dimensional mammogram, which enhance the ability to detect breast cancer at an even earlier stage, therefore increasing the likelihood of effective intervention and lowering the possibility of a false positive," Yuri Parisky, M.D., Medical Imaging Director and Radiologist, Mammoth Hospital.

- The hospital leadership and staff continue to immerse themselves into Mono County community as evidenced by our relationship with our local schools. As California high schools move towards requiring a hands-on CPR course for graduation, our Education Coordinator has trained a total of 393 students over the past two years in CPR and AED awareness. In addition, 98 community members were trained including from Hospital Auxiliary, Mountain Resort, and Health Science Pathway. Further, our growing Athletic Training Program of five trainers supported the high school student-athletes to aid in preventing injuries as well as treating them. Finally, our hospital's 4th of July float will focus on the importance of CPR and how it does save lives.

SUBSTANCE ABUSE GOALS

1. Provide education and raise awareness of the prevention and treatment of substance abuse (Drug, ETOH, Tobacco) and see an increased number of individuals seeking treatment.
    a. Provide education to the providers and clinical staff.
    b. Provide community education through collaboration.
2. Develop a Pain Management Program to serve the community's chronic pain population and see the number of community members obtaining opioid prescriptions for chronic pain

decline.

a. Develop a Chronic Non-malignant Pain Management Program based on the ICSI Health Care Guidelines: Assessment and Management of Chronic Pain (Project Designated under the Public Hospital Redesign and Incentives in Medi-Cal (PRIME) program).
b. Expand the Care Coordination Program.

PATIENT-FOCUSED PROCESS RESULTS

- The first Chronic Pain Multi-disciplinary Committee meeting was held in March 2017 and quarterly thereafter. The committee is chaired by our CMO and includes representatives from Physical Therapy, Occupational Therapy, Behavioral Health, Care Coordination, Dietary Services, and Family Medicine. The committee's goal is to review patients on high doses of opioid medication and develop multi-modal treatment plan with an aim toward reducing the dependence on opioids.

- A Chronic Pain Patient Registry for Medi-Cal patients was developed and is updated monthly. Patients on the registry with complex health issues are referred to Care Coordination for follow-up. Those on high dosages of opioids are referred to the multi-disciplinary committee for review.

- Family Medicine distributes the AUDIT and DAST-10 substance abuse screening tools to Medi-Cal patients. Over 200 patients were screened between July 2017 and May 2018.

- As Mono County has neither short- or long-term rehab centers to discharge substance abuse patients, a long-time hospital Spiritual Care Volunteer shared a packet with our Spiritual Care and Case Management departments of both inpatient and outpatient rehab clinics in the surrounding areas of Tahoe, Northern and Southern California. This has proven to be a valuable resource to patients and family members both during their stay and post-discharge.

- Readmissions continue to be a major opportunity for improvement in healthcare. About one-in-five Medicare patients who are discharged from the hospital return within 30-days. Between 50 and 75 percent of those readmissions are considered preventable. In an effort to improve transitions of care from the hospital to the community and to avoid costly Medicare penalties for 30-day readmissions, our multi-disciplinary Care Coordination Team continues its best-practice model by meeting bi-weekly to discuss our high-risk patients. The team continues to include our Chief Medical Officer/Physician Advisor, Case Managers, Patient Care Navigator, Chronic Care Manager, Registered Dietitian, and Spiritual Care / Patient Experience Manager. In addition, Case Managers continue to call patients three-days after discharge to ensure discharge instructions are understood and follow-up appointments are made. From July 1, 2017 through March 31, 2018, Mammoth Hospital had 19 patients out of 415 inpatients return to the hospital with unplanned, 30-day readmissions (4.6%). This rate is statistically well below our own internal benchmark goal of 8 percent or less as well as the national average. Our rate is so low, we were asked by the Hospital Improvement Innovation Network (HIIN) to present a webinar to hospitals to share our successful strategies and lessons learned in the reduction of hospital readmissions.

BEHAVIORAL HEALTH GOALS

1. Increase the awareness of behavioral health resources through education and see an increase number of community members accessing services.
    a. Collaborate with Mono County Behavioral Health to provide community education.
    b. Develop an educational handout for patients and families to be given to patients in the Emergency Department and in the Medical-Surgical Unit.
2. Develop additional behavioral health resources to serve the community and see an increase in the number of individuals accessing services.

a. Integration of Behavioral Health and Primary Care using the University of Washington Collaborative Care Model (PRIME project).
b. Investigate the possibility of Tele-psychiatry with an academic medical center.
c. Investigate the possibility of recruiting a full-time Psychiatrist for the Eastern Sierra.
d. Recruit a Marriage and Family Counselor for Mammoth Hospital.

PATIENT-FOCUSED PROCESS RESULTS

- Seeking to align our strategic plan with this CHNA, we have aggressively pursued offering Tele-psychiatry for both our outpatient and emergency services. As of January, we now have an outpatient agreement with UC San Diego through our Clinic. Also, formal conversations continue with California Emergency Physicians (CEP) to provide emergency tele-psych consults to our Emergency Department which will be paid for by Mono County Behavioral Health.

- Develop additional behavioral health resources to serve the community and see an increase in the number of individuals accessing services including:
    - Providing tele-psychiatry with an academic medical center led us to contract with Dr. Charles Saldanha to provide oversight of our Behavioral Health program and provide consultation to our Family Medicine providers in the area of Behavioral Health.
    - We have extended an offer to a full-time Psychiatrist to serve the Eastern Sierras.
    - We have successfully recruited a full-time Marriage and Family Counselor for Mammoth Hospital.

- Dr. Jacob Eide, LCSW, has begun seeing patients in the Family Medicine Clinic. He is available for providers to conduct warm hand-offs for patients who have behavioral health needs. Dr. Eide is currently working on integrating Behavioral Health into the Family Medicine Clinic using the University of Washington Collaborative Care Model (PRIME project).

- Family Medicine distributes the AUDIT and DAST-10 substance abuse screening tools to Medi-Cal patients. Over 200 patients were screened between July 2017 and May 2018.

- PHQ-9s are being administered at Family Medicine for Medicare and Medi-Cal patients. Family Medicine is practicing the "warm hand-off" in which patients with high-scores are immediately connected to either Behavioral Health or Care Coordination. Over 950 PHQ-9s were completed by patients between July 2017 and May 2018 (Medicare and Medi-Cal).

- Our hospital continues to use established social media, hospital web-site as well as traditional radio and newspapers to connect (and keep connected) with our community at-large. Examples range from our raising awareness via all of these various media arenas during Mental Health Month to posting on Facebook about our 'Good Grief Support Group' bi-monthly meetings (94 attendees), 'Cancer Support Group' (47 attendees), and 'Aging Parents Support Group' (12 attendees).

CHRONIC DISEASE GOAL

Improve community awareness of the long-term detrimental effects of obesity on health and see individuals with obesity participating in educational programs and seeking care coordination.

1. Develop formal educational programs.
2. Expand the Care Coordination Program.

PATIENT-FOCUSED PROCESS RESULTS

- Mono County Makes the List in First-Ever Community Health 2018 Honor Roll. In 2018, U.S. News Healthiest Communities Honor Roll recognized 36 communities with Mono County coming in at

#11! The honor roll is a component of *U.S. News & World Report*'s inaugural healthiest communities rankings, a project conducted in collaboration with Hartford, Connecticut-based Aetna's charitable foundation. The project scores nearly 3,000 counties on approximately 80 indicators across 10 categories: population health, equity, education, economy, housing, food and nutrition, environment, public safety, community vitality and infrastructure. According to *U.S. News & World Report*, the honor roll communities together have an average life expectancy of 81 years and health insurance coverage exceeding 90 percent.

- Readmissions continue to be a major opportunity for improvement in healthcare. About one-in-five Medicare patients who are discharged from the hospital return within 30-days. Between 50 and 75 percent of those readmissions are considered preventable. In an effort to improve transitions of care from the hospital to the community and to avoid costly Medicare penalties for 30-day readmissions, our multi-disciplinary Care Coordination Team continues its best-practice model by meeting bi-weekly to discuss our high-risk patients. The team continues to include our Chief Medical Officer/Physician Advisor, Case Managers, Patient Care Navigator, Chronic Care Manager, Registered Dietitian, and Spiritual Care / Patient Experience Manager. In addition, Case Managers continue to call patients three-days after discharge to ensure discharge instructions are understood and follow-up appointments are made. From July 1, 2017 through March 31, 2018, Mammoth Hospital had 19 patients out of 415 inpatients return to the hospital with unplanned, 30-day readmissions (4.6%). This rate is statistically well below our own internal benchmark goal of 8 percent or less as well as the national average. Our rate is so low, we were asked by the Hospital Improvement Innovation Network (HIIN) to present a webinar to hospitals to share our successful strategies and lessons learned in the reduction of hospital readmissions.

- The Chronic Care Management Program for Medicare patients currently has over 100 patients participating. While not obesity-specific, Medicare patients with chronic conditions / complex health needs do qualify for this program.

- Diabetes Patient Registries for Medi-Cal and Medicare patients have been developed and are updated monthly. Patients on the registry with uncontrolled diabetes are tracked and referred for diabetes education as appropriate. The registries also help pinpoint patients who have not recently been seen by their providers. Population Health collaborates with Family Medicine to ensure patients return for follow-up.

- On June 22, the 6-week Stanford University Evidence-Based Chronic Disease Self-Management Workshop is scheduled to begin. The workshop is open to any community member with a chronic condition.

- Our multi-disciplinary Total Joint Replacement Program (TJRP) has established criteria for patient readiness to ensure best practice for safe and optimal outcomes. TJRP patients continue to be evaluated on a multi-disciplinary basis to identify risk behaviors and co-morbidities including, smoking, alcohol and drug use, depression, hypertension, and obesity. For obese patients, i.e. who are above a Body Mass Index (BMI) of 35, they must meet with our Masters-prepared Dietitian and reach the goal of <35 BMI to schedule surgery. Future plans include integrating into our Meaningful Use, The American Joint Replacement Registry (AJRR) metrics. AJRR is dedicated to improving orthopaedic care through collecting, analyzing, and benchmarking data on total hip and knee replacements from across the entire United States.