Project Name: Grady Memorial Hospital – The Center for Advanced Surgical Services

Project #: 102069.00

Meeting: Core Team Kick-Off

Date: 10-24-2017

Location: Grady Memorial Hospital: 2C120 Conference Room

Attendees: Stephen Smith, Darrell Robinson, Shannon Sale, Carlos Ruiz, George Smith, LaShondra Hubert, Teri Oelrich, Janet Susi, Mark Koechling, Susan Bower, Andrea Rufe, Tom Fox

AGENDA: See attached agenda

**USER COMMENTS**

1. Introduction/Roles
	1. Darrell Robinson (Grady) – Project Manager and logistics
	2. LaShondra Hubert (Grady) – Program coordinator
	3. Shannon Sale (Grady) – Chief Strategy Officer
	4. Steve Smith (Grady) – Dir. Facilities Development
	5. Carlos Ruiz (Grady) – Support Services/Facilities Management
	6. George Smith (Grady) – Architectural Project Manager/Building History
	7. Teri Oelrich (NBBJ) – Partner-in-Charge
	8. Janet Susi (NBBJ) – Lean/Process Improvement
	9. Susan Bower (NBBJ) – Clinical/Healthcare Planning
	10. Mark Koechling (NBBJ) – Project Manager
	11. Andrea Rufe (NBBJ) – Analytics/Planning
	12. Tom Fox (NBBJ) – Architecture/Medical Planning
2. Set Leadership Goals
	1. Goals & Aspirations
		1. Facility that will raise ambulatory care standards
			1. Want people to see and to be excited about what Grady is doing
		2. To “claim” the intersection (Jesse Hill Jr Drive & Gilmer St)
			1. Create a gateway and help define a “front door”
		3. Operationally expandable in a way that makes sense
		4. National recognition
			1. Get past the negative mindset that originated from the Olympics
		5. Tie into the existing facility, but be different
			1. New innovative model – from arrival to departure
		6. Environmentally and operationally sustainable
		7. Flexibility/adaptability throughout the entire building
			1. Extend the avoidance of obsolescence
		8. Environment of warmth and safety (not just an area of refuge)
		9. Do not compromise developed key objectives
		10. Opportunity to create an ambulatory experience from the ground up
			1. Concern that Grady is already behind on providing the optimal experience
			2. Needs to work for the patients, physicians and staff
		11. Sustainability (need to get beyond the acute experience)
		12. Concern regarding schedule and capacity to implement this project
		13. Don’t want to replicate existing model
		14. Make sure population is taken care of with a better level of care
		15. Ergonomics and superior functionality
		16. Don’t waste space with unusable or under-utilized areas
		17. Integrated with the main hospital – don’t be a silo
	2. Expanding over time (further discussion)
		1. Within the site
			1. Vertical growth is more expensive than horizontal – the Board may consider structuring for this
			2. Size of site is limited
		2. Think about the orientation and arrangement of parking with the change of vehicle use in the future – what are the opportunities to bury?
			1. Grady is at the water table – lower levels become very expensive
		3. Orient the primary building circulation so that it can be naturally extended into future park space
		4. This building could potentially be a relocation of Radiation Oncology in future
			1. Current building is about 20 years old but with a relatively new linear accelerator
			2. Think about location of Cancer Center in the CASS
		5. Patients tend to come from a longer distance and often come early
		6. Set up structure appropriately for some areas of large assembly
		7. Plan for data capacity & mechanical systems to grow in the future
	3. Not repeating what has been done (further discussion)
		1. Existing buildings and infrastructure has limited what could be done in the past
		2. But need to make sure this doesn’t limit thinking of future possibilities
		3. Much of the existing design is based on “traditional” department layouts
			1. Need to re-focus on the patient experience
		4. Patient access to community health
			1. There are logjams due to limits of transportation now that most housing has been pushed farther away – create filled public spaces
			2. Need to be mindful of how public transportation works
		5. Grady is a teaching hospital – Emory and Morehouse
			1. Teaching creates certain inefficiencies (i.e. longer wait/case times, more support spaces)
			2. CASS should not support teaching outright, but create (very) limited space for resident teaching
			3. Physicians are not aware of the new clinical throughput goals
			4. Current LOS are significantly above national standards
	4. Don’t create wasted space (further discussion)
		1. “Stretch the code”
			1. 5’-6” wide corridors where appropriate but also think about future potential of space that may require wider corridors
			2. Standardizing is important to flexibility
3. Impediments to the Process
	1. Need the people who are key to the process development available when needed
		1. Want to ensure participants attend for entire meeting and come back
		2. All participants need to be heard, help develop the processes and buy-in to project
		3. Variation in practices are causing longer waits and clinic utilization is a problem
	2. Getting staff to the Fulton County Building because there is not a direct connection to the main hospital
		1. But it is just across the street so that should not be too difficult
		2. Has good space for meetings and mock-ups
	3. Meeting scheduling strategies
		1. 10a-12p generally not good for acute rounding, but this project will be primarily ambulatory
		2. Need to determine if early mornings or evenings will work best for surgery
			1. Leaning toward evenings with food provided
	4. Should get staff thinking and working on process improvements now
	5. Staff not only need to be at the meetings, but need to be there at the same time to hear each other’s comments
		1. Need to stress the importance of everyone’s participation
		2. Having agendas can be helpful to increase attendance
		3. Need to enable key staff members to pass down information to their staff who are not invited to meetings to broaden thinking and buy-in
	6. Opportunities
		1. There is a consistent location for meetings and mock-ups
		2. Can integrate teams so that each specialty hears what others contribute
4. Design Criteria (programming/planning)
	1. Patient/family experience
		1. Clear and simple wayfinding is key
			1. Grady is currently working on strategies to improve wayfinding
		2. Utilize daylight – get light deeper into building
			1. Be careful of heat gain from south-facing windows
		3. Balance design and durability (and perception of money spent)
		4. Looking to serve a broad spectrum of the community
			1. Want to capture more than just the underserved/indigent clientele
			2. Want to be able to make people from varying backgrounds cohabit the same space comfortably (some people feel very vulnerable)
		5. How best to bring services to the patient and what does that do to the staff and support spaces?
		6. Safety and security of the environment
	2. What are the scarce resources (i.e. nursing) and how best to deal this?
		1. Very low unemployment in Atlanta (1%) – there is a lot of competition
		2. There is also competition internally for nurses
			1. There is not a nurses union
		3. Will need to recruit the best support staff (i.e. security, facilities, environmental services, etc.) – how can this be accomplished?
	3. Physical attributes of space
		1. Ease of access from garage to CASS
		2. Future bridge to the main hospital is currently seen as a clinical/support staff connection (not patient or materials)
		3. Desire a sense of openness (light and color) without being grandiose
		4. Current patient privacy issues are primarily at check-in point
5. Planning Brief
	1. Target users
		1. No external partners
		2. Clinical staff and support team to attend user-group meetings
		3. Patient/family groups
		4. Emory and Morehouse physicians
			1. Physicians are hospital employed (agreements with universities)
			2. General, GI and Oncology currently share the same space
			3. The two groups do not share clinics but procedural space
			4. The new clinics should bring both sides together
			5. New facility should be able to attract and help retain physicians
			6. ED is the only group that’s lead by Grady, but supported by Emory
		5. Imaging – hospital based
		6. Pharmacy
			1. To support Oncology
		7. Laboratory – hospital based
			1. Will use for Oncology and POC testing
			2. Currently dealing with issue of what does/doesn’t go to the main lab from the ambulatory setting on another project and is not yet settled
			3. Current issue with the process around chemo mixing and quantity of infusion stations
		8. Outpatient Pharmacy
			1. OP pharmacy was relocated due to the ED trauma expansion and is not in the best location to serve patients
			2. There is a note in the master plan that the CASS may be the right location for OP pharmacy in the future
			3. Current thought is that the pharmacy component in CASS should just support primary scripts
		9. Oncology (Infusion Center)
			1. Built about 10 years ago and has become a primary destination – clinic volumes continue to grow
			2. 17,000 cancer patients discharged annually
			3. Not partnered with any other oncology centers
		10. Overall clinic volume increases 2-5% annually
			1. Trauma clinic will also be included as part of these clinics
		11. Education space for patient
			1. Broad approach to use of space
		12. Central scheduling will stay in place
	2. Constraints (things to be prepared for)
		1. Limited area for loading dock/service area (energy plant)
		2. Want to minimize access points for security control
			1. Need to think about after-hours access – there has been limited opportunity for community education because housing has been pushed farther away from the hospital
			2. Education component is more about group clinical use (i.e. diabetes care)
		3. Traffic patterns
			1. These are not going to change
			2. One-way and limited two-way vehicle traffic (Gilmer is two-way, Jesse Hill Jr is one-way) in front of hospital but two-way past the parking deck and Piedmont is one-way north
		4. What is the best practice for support services?
			1. Need to education staff on best practices
			2. Central or satellite (blood bank, central sterile)?
			3. CSP will likely want to process everything centrally – need to discuss process
		5. Future bridge
			1. Makes sense from a staff (physician) perspective
			2. Not sure if it should serve patients
			3. Could potentially connect to the new parking garage – parking is a critical need at Grady
		6. Parking
			1. County has committed to funding 50% of the bond for the CASS, but parking will be separate
			2. Garage could be developer-funded or need to figure out how Grady will fund
			3. Currently charge $5 flat-rate for parking – concern that a developer would increase price
		7. Budget
		8. Getting staff to participate/engage at meetings
		9. Current operational “silos”
			1. Can be difficult to pull teams together
			2. New ambulatory should not be siloed from main hospital or other ambulatory buildings
				1. But this building will be only for ambulatory services
			3. Some therapies will remain in the main hospital, separate from the clinics (i.e. radiation oncology, brachy therapy)
				1. Ortho trauma is separate from the ortho clinic and will remain in main hospital – thought is that trauma will weigh down the ambulatory processes
			4. Scheduling has recently be centralized (Hurt building?)
				1. Scheduling process should be looked at – there is room for improvement
				2. There are still different systems in place by department
			5. Functional silos
				1. ED is separate from inpatient which is separate from ambulatory
				2. Will plan on having interdisciplinary user-groups to start bridging these gaps but need to make sure they talk to each other during meetings and not wait to discuss concerns offline
	3. What is currently working well?
		1. People are excited about this project
		2. The location is relatively easy to get to
		3. Annual surgery volumes on track for 13,800 and heading toward 14,500
			1. Due to operational leadership and having dedicated staff on campus
		4. Ophthalmology runs very “tight ship” and don’t want to create issues that will interrupt their processes
		5. Grady has become a place where outside vendors want to come to work and contribute – competitive environment
		6. Chronic care graduation testimonials that were focused not just on care but on how staff go above and beyond connecting patients to housing and jobs
		7. Many physicians, who could make more money elsewhere, want to work at Grady – they are believers in the mission
		8. ED physicians are well respected by patients
			1. Unfortunately 80% of admits come from ED – there’s not really a direct admit process and many outside physicians don’t know that that can
			2. 5 – 6 patients per day are admitted from the clinics
	4. Expected Outcomes
		1. Increase in clinic volumes
		2. Addition of physicians
		3. Improve overall metrics
		4. Elimination of operational “silos”
6. Introduction to the Project
	1. Core Team (this group)
		1. Directs overall course of the project
		2. Logistics and process
		3. Weekly coordination call
	2. Leadership Team
		1. Help craft information that gets distributed
		2. Participants:
			1. Core Team
			2. Dr. Rhonda Scott (COO)
			3. Dr. Robert Jansen (CMO)
			4. Michelle Wallace (Lab, other?)
			5. Dr. Kelly Clarro (ambulatory)
			6. Craig Tindel (service lines)
			7. Dr. Jackie Herd (CNO)
			8. Dr. Peter Rhee (Chief of Surgery)
			9. Ben McKeeby (CIO)
			10. Lindsey Caufield (Public Affairs – patient experience)
	3. CEO Council & Executive Planning
		1. CEO Council meets 3 hours every Tuesday (includes John Haupert and reports to the Board)
		2. Executive Planning meets 1st and 3rd Thursdays of every month
		3. CASS project should become an agenda item at some of these meetings
		4. Propose meeting with senior leadership approx. six times over the course of the project
		5. What will be the appropriate level of their input?
			1. Works well to meet with leadership on Thursdays so the Core Team can provide a succinct wrap-up for that week’s meetings
		6. Identified dates on the project calendar for meeting with both groups
	4. Core Team Responsibilities
		1. Scheduling
		2. Meeting participation (list of who)
		3. Communication plan (dissemination of information)
		4. Meeting room coordination
		5. Identification of sub-consultants
		6. Issue resolution/escalation
		7. Agenda development for Executive Planning meetings (and presentation structure)
		8. Meeting minute review (7-day turn around on minutes)
		9. Budget responsibility/monitoring
		10. Guiding principles and project vision
		11. Identification of tour participants
		12. Lead and issue RFP for final architectural selection (present to key decision makers)
	5. Executive Team Responsibilities
		1. Confirm guiding principles and vision of the project
		2. Confirmation of programmatic elements
		3. Input on operational model – alignment of best practice
		4. Communicate/feedback to Core Team of any issues heard
		5. Coordination of what is communicated to the Board and their direct reports
		6. Coordination of communication to media, public, marketing, etc
		7. Budget/scope change confirmation
		8. Final approval
		9. Approval/awareness of CON strategy
		10. Approve architect selection (a portion of this group with the Core Team)
	6. Guidelines
		1. George uses FGI 2014 and will immediately adopt 2018 when it is published
	7. Project Approach Timeline and Calendar (handout)
		1. Reviewed schedule
		2. Observation
			1. Focus on future state (not current state) process
			2. Observation more about connection to staff’s current environment and allows team to understand their challenges
		3. Executive Planning meets on Nov. 13th – would be good to touch base
		4. On-site meetings:
			1. Nov. 15th – 16th
			2. Dec. 4th – 8th
			3. Jan. 8th – 12th
			4. Feb. 6th- 9th
			5. Feb. 28th – March 2nd (may be able to move meeting if necessary)
			6. Board meeting on March 12th (will need material a week in advance)
7. Building the Team Structure
	1. Communication Plan
		1. Mark should be copied on all correspondence with Nbbj
			1. Mark will communicate directly with Darrell (copy Shannon and Steve)
		2. Darrell should be copied on all communication with Grady
		3. Teri should communicate directly with Steve and Shannon
		4. Janet should communicate directly with George and Shannon
		5. Susan should communicate directly with Shannon
		6. Tom Fox will communicate primarily with George (and Steve)
		7. Andrea will communicate primarily with Shannon
		8. Communication to senior leadership will come from the Core Team
		9. Email direct pertaining to responsibility and CC for information only
	2. User-Groups
		1. November meetings will be 1.5 – 2 hours in length
		2. December meetings need to be figured out
		3. Groupings
		4. Facility Support Services- IT, EVS, Food Services, Etc.
		5. Clinical Services- ENT/Eye/GI Clinic/Surgery Clinic/Cancer/Ortho/Oral Surgery
			1. Oral Surgery (procedural more than surgical)
			2. They are onsite for trauma but do perform surgeries offsite
			3. Primarily clinical
			4. Currently looking at how this group could be integrated with Plastics
		6. Procedural Services- Surgery Center, GI Procedure, Anesthesia, Central Sterile, Imaging, Cancer Infusion, Nuclear Med., etc.
		7. Patient Support
		8. Clinical Support- Pharmacy, Clinical Lab, Blood Bank, RRT, Nursing, HR, etc.
		9. Catch All Meetings

**NEXT STEPS:**

1. Grady Action Items
	1. Contact Pooja to get us the patient registry for cancer patients & Receive information- Darrell
	2. Send the Emory/Morehouse Service Strategic Plan to get to “One Grady”- Shannon
	3. Approve future meetings and user groups; send out invitations- especially email letter to the physicians- Steven/Shannon/Darrell
2. NBBJ Action Items
	1. Confirm future travel dates- Mark/Teri
	2. Assemble Project Directory- Mark
	3. Create and distribute agenda for November Meetings- Janet
	4. Confirm user group groupings for November meetings- Teri first pass; Team approval
	5. Identify other areas to visit and observe- All
	6. Send updated website address and password- Andrea