STRATEGIC PLANNING COMMITTEE MEETING
OF THE BOARD OF DIRECTORS

JULY 9, 2013
10:00 A.M.
HHC BOARD ROOM
125 WORTH STREET

AGENDA

I. CALL TO ORDER — **JOSEPHINE BOLUS, RN**

II. ADOPTION OF JUNE 11, 2013 STRATEGIC PLANNING COMMITTEE MEETING MINUTES — **JOSEPHINE BOLUS, RN**

III. SENIOR VICE PRESIDENT'S REPORT — **LARAY BROWN**

IV. INFORMATION ITEM:

i. **STATE LEGISLATIVE UPDATE**

WENDY SAUNDERS
ASSISTANT VICE PRESIDENT, OFFICE OF INTERGOVERNMENTAL RELATIONS

V. OLD BUSINESS

VI. NEW BUSINESS

VII. ADJOURNMENT — **JOSEPHINE BOLUS, RN**

MINUTES

STRATEGIC PLANNING COMMITTEE MEETING OF THE BOARD OF DIRECTORS

JUNE 11, 2013

The meeting of the Strategic Planning Committee of the Board of Directors was held on June 11, 2013, in HHC's Board Room located at 125 Worth Street with Josephine Bolus presiding as Chairperson.

ATTENDEES

COMMITTEE MEMBERS

Josephine Bolus, NP-BC, Chairperson of the Committee
Alan Aviles
Anna Kril
Bernard Rosen
Michael A. Stocker, M.D., Chairman of the Board
Andrea Cohen, representing Deputy Mayor Linda Gibbs in a voting capacity

OTHER ATTENDEES

M. Dolan, Senior Assistant Director, DC 37
C. Fiorentini, Analyst, New York City Independent Budget Office
M. Meagher, Budget Analyst, Office of Management and Budget
K. Raffaele, Analyst, Office of Management and Budget
J. Wessler, Guest

HHC STAFF

M. Belizaire, Assistant Director of Community Affairs, Intergovernmental Relations
L. Brown, Senior Vice President, Corporate Planning, Community Health and Intergovernmental Relations
T. Carlisle, Associate Executive Director, Corporate Planning Services
D. Cates, Chief of Staff, Office of the Chairman
L. Guttman, Assistant Vice President, Office of Intergovernmental Relations
T. Hamilton, Director, HIV Services, Corporate Planning Services
L. Hansley, Director, Organizational Innovation, and Effectiveness
S. James, Coordinating Manager, Harlem Hospital
L. Johnston, Senior Assistant Vice President, Medical and Professional Affairs

J. Jurenko, Senior Assistant Vice President, Office of Intergovernmental Relations
S. Kleinbart, Director of Planning, Coney Island Hospital
Z. Liu, Senior Management Consultant, Corporate Planning Services
P. Lockhart, Secretary to the Corporation, Office of the Chairman
T. Mammo, Chief of Staff, President's Office
A. Marengo, Senior Vice President, Communications and Marketing
A. Martin, Executive Vice President and Chief Operating Officer, President's Office
H. Mason, Deputy Executive Director, Kings County Hospital Center
K. McGrath, Senior Director, Communications and Marketing
I. Michaels, Director, Media Relations, Communications and Marketing
J. Omi, Senior Vice President, Organizational Innovation, and Effectiveness
K. Park, Associate Executive Director, Finance, Queens Health Network
S. Penn, Deputy Director, WTC Environmental Health Center
S. Russo, Senior Vice President and General Counsel, Office of Legal Affairs
J. Wale, Senior Assistant Vice President, Behavioral Health
R. Wilson, M.D., Senior Vice President, Corporate Chief Medical Officer, Office of Medical and Professional Affairs
K. Whyte, Senior Director, Corporate Planning, Community Health and Intergovernmental Relations

CALL TO ORDER

The meeting of the Strategic Planning Committee was called to order at 10:10 a.m. by the Strategic Planning Committee Chairperson, Josephine Bolus, RN. The minutes of the April 9, 2013, meeting of the Strategic Planning Committee were adopted.

SENIOR VICE PRESIDENT REMARKS

Ms. Brown greeted and informed the Committee that her remarks would include brief updates on federal, city and state issues.

FEDERAL UPDATE

Medicare Disproportionate Share Hospital (DSH) Funding Proposed Rule

Ms. Brown reported that, on April 26, 2013, the Centers for Medicare and Medicaid Services (CMS) had issued the Medicare Inpatient Prospective Payment System (IPPS) proposed rule for Fiscal Year (FY) 2014. As a result of that rule, hospitals will experience an average payment decrease of 0.1% in FY 2014 compared to FY 2013. The proposed rule also includes CMS' proposal to implement the Affordable Care Act's (ACA) Medicare Disproportionate Share Hospital (DSH) changes.

Ms. Brown announced that, beginning on October 1, 2013, and as mandated by the ACA, each hospital will receive 25% of their traditional share of Medicare DSH payments. However, part of the remaining 75% will be used for savings (approximately $1 billion in FY 2014), and the rest will be redistributed through a new "uncompensated care payment" (approximately $8 billion to be redistributed in FY 2014). Ms. Brown explained that the portion of the 75% that will be used for savings would increase in future years as the national uninsured rate decreases. Ms. Brown reported that only hospitals that qualify for Medicare DSH payments would be eligible to receive uncompensated care payments. HHC expects to see an increase in Medicare DSH payments under this new formula but the amounts are uncertain. She explained that a concern was CMS' likely use of hospital cost (i.e., hospital cost work sheet S-10) that is known to be significantly flawed.

Ms. Brown explained that CMS had proposed to distribute uncompensated care payments using each hospital's share of national total "low-income days," defined as Medicaid days + Medicare SSI days. Ms. Brown added that HHC was working with the Greater New York Hospital Association (GNYHA), the National Association of Public Hospitals (NAPH), the Healthcare Association of New York State (HANYS) and others on proposals that would enhance the amount of funds that would be "redistributed" to safety net hospitals and the addition of psychiatric rehabilitation days in this calculation. The addition of psychiatric rehabilitation days would be beneficial to HHC.

Ms. Brown shared with the Committee a concern regarding CMS' proposal to distribute DSH funds on a periodic interim basis, which would be most beneficial for Medicare Advantage health plans. She explained that the American Hospital Association (AHA) had estimated that $3 billion nationally would flow to Medicare Advantage plans instead of hospitals. This methodology would negate the gains of $59 million that HHC had estimated that it would gain from the new uninsured pool under the CMS proposed methodology. Ms. Brown noted that the intent was to use Medicaid fee-for-service in the calculation. She announced that comments to CMS concerning this IPPS (Medicare DSH) rule were due on June 25, 2013. She added that HHC's self-imposed deadline of June 24, 2013, would ensure that the requisite reviews and signatures would be in place to assure that HHC meets CMS' submission deadline. Ms. Brown informed the Committee that HHC staff had been in communication with the New York trade associations, in particular,

to ensure that they are on the same page as HHC. Ms. Brown added that it was also important that NAPH's and HHC's comments were well-aligned. She noted that multiple comments with the same message from organizations with influence could be helpful. Ms. Brown informed the Committee that, Mr. Leonard Guttman and Mrs. Judy Chesser, Assistant Vice Presidents of HHC's Office of Intergovernmental Relations had also briefed the New York City delegation on the implications of the proposed rule. It is hopeful that the respective comments from the national organizations and the state trade associations would have a positive impact.

Medicaid Disproportionate Share Hospital (DSH) Funding Proposed Rule

Ms. Brown reported that, on May 13, 2013, CMS had released a proposed rule to implement the Medicaid Disproportionate Share Hospital (DSH) payment cuts mandated by the Affordable Care Act (ACA). She stated that CMS' proposed formula for calculating cuts to Medicaid DSH payments was designed to provide states with an incentive to target DSH payments to those hospitals serving the most low-income patients. Ms. Brown explained that the federal government cannot mandate such targeting for Medicare DSH but it can distribute the Medicaid DSH cuts in a manner that would provide an incentive to states to target hospitals serving low-income patients. Ms. Brown reported that CMS would use state auditing data to determine the extent to which states were targeting DSH payments to hospitals with high levels of uninsured or uncompensated care. Moreover, CMS is adding to future audit reports a requirement that states report total hospital costs. Ms. Brown noted that this proposed rule would be for the first two years, FY 2014 and FY 2015. A new rule will be issued in the coming years after more is known about Medicaid expansion in the various states. Ms. Brown stated that the preliminary estimates for the Medicaid DSH cuts showed that New York State and HHC would be cut less than what had been originally assumed. Ms. Brown reminded the Committee that across the nation, the overall Medicaid DSH cut was still projected at 5% while the projected cut for New York State would be 3.8% in the proposed rule. Ms. Brown noted that, if this rule goes through as it is currently written, the specific impact on HHC would remain uncertain because it would depend on what the state would do to get its allocation.

Immigration Reform

Ms. Brown reported that the Border Security, Economic Opportunity, and Immigration Modernization Act had been scheduled to be brought to the Senate floor during the second week of June for consideration, with changes and amendments to this Act expected over the course of several weeks. Ms. Brown added that this comprehensive immigration legislation would allow undocumented immigrants who were present in the United States to enter a path to citizenship that would include 10 years as a Registered Provisional Immigrant (RPI) before they would become eligible to become a Legal Permanent Resident (LPR) and to receive a green card. Moreover, after converting to LPR, RPIs must wait another five years after receiving their green card before they would be able to access Medicaid or CHIP, equaling a total of 15 years that immigrants must wait to be eligible for federal health care coverage. Ms. Brown noted that so far, undocumented immigrants do remain eligible for Emergency Medicaid. She stated that, in the House, where no comprehensive bill had been introduced, immigration talks were snagged on what kind of health benefits should be made available to undocumented immigrants seeking U.S. citizenship. Some Republicans in both houses support a proposal to make it mandatory for those on the path to citizenship to acquire health insurance but no subsidization would be allowed.

Mrs. Bolus, Committee Chairwoman, asked what health care options would be available for uninsured immigrants who were not on the path of seeking U.S. citizenship. Ms. Brown responded that in New York City, these individuals would continue to access public hospitals and community health centers. She added that, across the country, public and safety net hospitals or federally qualified health centers (FQHCs) would remain their only option for health care services. Ms. Brown noted that HHC would continue to receive reimbursement from the state's indigent care pool.

State Update

Ms. Brown reported that the State Legislature was expected to complete its 2013 session next week. She stated that there were a number of bills that were being considered that could significantly impact HHC. She reminded Committee members that there continued to be a big push – both for and against – on two bills related to nurse staffing: one mandating stringent nurse staffing ratios for hospitals and nursing homes and a second that would create a new Safe Patient Handling Program that mandated specific and inflexible new equipment, technology and staffing requirements for health care facilities. Ms. Brown stated that, while HHC supported the goal of the bills to improve patient safety and quality, the latest research indicated that simple mandates alone, which would require hundreds of millions in new spending for HHC, were not likely to achieve the intended outcome.

Ms. Brown reported that other legislation being considered would impose new requirements on hospitals to screen certain patients for Hepatitis C and to provide notices to patients in Observation Units clarifying that they have not been admitted to the hospital and detailing potential health insurance implications. In addition, the Legislature is considering a bill that would: 1) limit compensation and benefits for HHC employees (and those of other state and local authorities) to "similar" levels as civil service employees; and 2) prohibit bonuses for employees unless they were ratified by the Board and part of a written agreement with measureable performance goals. Ms. Brown stated that HHC also expected a last-minute push for legislation on a variety of liability and malpractice issues. She added that HHC would continue to remain vigilant on those and other proposals as the session drew to a close.

Ms. Brown informed the Committee that the Senate had held a hearing on the future of SUNY Downstate and the proposed Sustainability Plan SUNY that had been developed as required by the recently enacted State Budget. Ms. Brown reported that the State Department of Health and the Division of Budget were evaluating the Plan. She noted that it was unclear whether or not there would be action on legislation to create a new Brooklyn Health Improvement Public Benefit Corporation, which had been envisioned as part of SUNY's Plan.

City Update

<u>HHC Testifies Before City Council</u>

Ms. Brown reported that HHC had provided testimony on the FY 14 Executive Budget and Financial Plan before the City Council at the end of last month. She added that members of the Council had asked many questions that ranged from the status of HHC's application seeking FQHC designation for its diagnostic and treatment centers (D&TCs) to the level of programmatic funding that was needed to be restored to the size and scope of its new electronic medical record system. Ms. Brown stated that HHC would be seeking $8.5 million in funding that was restored last year but not base-lined. She explained that this funding would support HHC's child health clinics, expanded HIV-testing, and certain behavioral health programs. Ms. Brown concluded her remarks by stating that the Council and the Administration would be negotiating the budget in earnest over the next two weeks with the goal of adopting the budget by the end of the month, if not sooner.

Mrs. Bolus invited Ms. Joanna Omi, Senior Assistant Vice President to conduct the Breakthrough presentation. Michael Stocker, M.D., Board Chairman commented that, contrary to the previous Breakthrough presentations, this 60-page presentation is a comprehensive report, which included the history of Breakthrough and its accomplishments. He added that Ms. Omi would not be reviewing every slide as some slides were being provided for information purposes only.

INFORMATION ITEM

Breakthrough - Developing a Culture of Continuous Improvement
Joanna Omi, Senior Vice President, Division of Organizational Innovation and Effectiveness

Ms. Omi greeted Committee members and invited guests. She stated that her presentation was a historical document which highlighted the Corporation's Breakthrough journey from its inception through the present. She informed the Committee that her presentation would cover the following topics:

- Why we came to Breakthrough
- Origins and definition of Breakthrough
- Expectations
- Achievements
- Return on Investment
- Continuous Improvement

Ms. Omi described the key challenges that the Corporation had been faced with in the 1990s as including:

- Several HHC facilities faced with the possible loss of Joint Commission accreditation
- City attempts to decrease the size of the system by selling or privatizing certain facilities
- Private payers across the country move to managed care and reduction of payments to providers; suddenly public hospitals have to compete for Medicaid patients
- HHC rallies:
  - Restructure financial relationship with the city
  - Bring budget into balance for five years in a row
  - Establish credit worthiness with bond rating companies
  - Dr. Luis R. Marcos becomes the longest tenured president

To address these challenges, Ms. Omi reported that HHC made dramatic progress in quality and in its operational and financial domains. In the 2000s, some of HHC's achievements included:

- Standardization of Asthma treatment; 25% reduction in the rate of hospitalization for kids with asthma
- Establishment of a Diabetes Registry; 46% of diabetic patients have 'healthy' blood sugar levels
- Reduction of 90% in ventilator acquired pneumonia (VAP) rates
- Introduction of value analysis in facility finance offices, resulting in immediate local revenue improvements
- Decrease in primary care appointment cycle times from 130 minutes to 60 or less, and no-show rates dropped from more than 40% to below 20%
- Team-based efforts – the whole is greater than the sum of its parts - produced:
  - Interdisciplinary approaches
  - Sharing best practices
  - Employee-based problem-solving

Ms. Omi reported that, even with these achievements, HHC's gains had been too fragile, improvements were difficult to sustain and drop-off rates had remained high. She explained that improvements were too easily dissolved when individual champions would leave HHC; and that improvements were isolated and large swaths of the workforce were not engaged.

Ms. Omi reported on HHC's approach to resolve the lack of sustainability of its improvement initiatives. HHC researched Six Sigma and the Toyota Production System (TPS) or Lean. The TPS System was found to be a more ideal approach for HHC because of:

  - Demonstrated success at Denver Health, a sister public hospital
  - Demonstrated success at Virginia Mason and ThedaCare
  - TPS/Lean is 'HHC-friendly':
    - Recognizes the need to engage and value the entire workforce
    - Simple, widely acceptable tools
    - Range of applications from strategic planning to human development to clinical, operational and financial improvements
    - Embedded sustainment processes
    - Top-down leadership direction and bottom-up innovation

Ms. Omi reported that HHC made a commitment to hire external consultants/experts to develop core teams at each site and develop a system-wide improvement effort.

Ms. Omi described HHC's plan for improvement and its expected return on investment through its employment of a system-wide improvement effort. To measure success, Ms. Omi explained that HHC used a balanced scorecard, with an unwillingness to sacrifice quality for financial gain. True north metrics included a focus on quality/safety, human development, throughput/delivery, financial and growth/capacity. HHC's capacity building plan included a plan for self-reliance and for exploring staffing models.

Ms. Omi described HHC's initial model as the following:

- Three year contract developed
- Year 1 consultant spend: $1.7 million
  - Sensei at each active site 1-2 weeks/month
  - Initially assumed consultant need would diminish after 12 months with 6-12 months for full 'weaning'
- Staffing model: Deployment Officer and 2-5 facilitators/trainers per site (estimate $300,000 to $650,000/site annually)
- Corporate office with enterprise staff (training, development, standardization, corporate level improvement) (estimate an additional $500,000)
- Cost of staff temporarily deployed to improvement activities or 'embedded' in operations NOT included (these staff would otherwise be paid and variation per event and per site are too great)

Ms. Omi defined Breakthrough as HHC's name for 'Lean', or the Toyota Production System (TPS). Toyota's founder, Sakichi Toyoda, made looms. The origins of TPS began with his invention of the Automatic Type G Loom that stopped automatically if a thread broke; no longer would defects in cloth be sent 'down the line.' His principle of 'autonomous automation', or Jidoka, the concept of, *'automation with a human touch',* launched an approach to work that would become TPS. Toyoda's descendents and Taiichi Ohno, a loom mechanic, further developed the concepts, principles, and values that define TPS.

Ms. Omi described HHC's goals and achievements. HHC's goals were to eliminate waste, overburden, and unevenness – everywhere – to allow employees to work efficiently; standardize processes to ensure consistent quality and safety; and to continually improve (kaizen). Ms. Omi stated that incremental improvement is achieved through the institutionalization of a daily management system (DMS). Big bang improvements are achieved through Rapid Improvement Events/Value Stream-based activities. Ms. Omi noted that the sum of these two improvements added together produced results in continuous improvement through Breakthrough.

Ms. Omi shared with the Committee a video statement that was prepared by Mr. Aviles, HHC's President, which described HHC's Breakthrough initiative. Mr. Aviles' video statement is provided below:

> "Breakthrough really is about taking our greatest asset, which is our workforce, our employees, who have so much experience doing what they do treating them as the world's greatest experts

> of the things we are trying to improve and really accessing that creativity and helping them to redesign the work that they do in ways that will increase their satisfaction as well as patients' satisfaction and give us more efficient operations."

Ms. Omi stated that this video clip, which was created in 2009, was still right on target. To date, this video is still being used corporate-wide as part of the new employee orientation. Ms. Omi noted that this video exemplified the simplicity of Breakthrough. She noted that, as part of top down leadership, Mr. Aviles participates in several rapid improvement events (RIEs) a year to make sure that he is credible and knows what it is he is asking people to do.

Ms. Omi highlighted the major milestones of the Breakthrough initiative for the period starting 2007 through 2013 which is presented in the chart provided below:

Building Internal Capacity

MAJOR MILE-STONES	Evaluate Improvement Methods; Engage Simpler; Begin Development and Application of BES at individual Sites	Develop Basic Training Program; Build Additional Sites	Build Additional Sites	Begin Hoshin Kanri at Level 0; Training Program 2.0; Build Additional Sites	Initiate BDI	Hoshin Kanri Cascaded to Level 3; Begin DMS Development; Build Additional Sites	Begin DMS Testing
YEAR	2007	2008	2009	2010	2011	2012	2013
CONTRACT	$1.7m	$1.8m	$3.5m	$3.1m	$4.4m	$5.5m	-25%
FTES (cum.)	3	20	29	38.5	57.5	77	
FACILITIES	Enterprise QHC	CIH GHS JAC MET	H&HC CUMB ELM KCHC WDHL NCB BHE	LINC	HAR	REN BEL MOR	
EVENTS		17	165	276	295	316	330 (prjtd)
DMS	-	-	-	-	-	-	4

Ms. Brown commented that, while this presentation slide only showed the facilities' involvement in Breakthrough, it was important to note that there were corporate divisions, particularly the finance division, that were also engaged in Breakthrough work. Ms. Omi agreed and added that other corporate offices had also been engaged throughout the Breakthrough process including the finance division under the leadership of Mrs. Marlene Zurack, Senior Vice President/Chief Financial Officer in 2007; long term care through Ms. Brown's division; and communications through Ms. Ana Marengo. Other areas that have been involved in Breakthrough included behavioral health services and corporate construction management in late 2011.

Ms. Omi described the Breakthrough implementation process. She stated that Breakthrough starts with a vision of the future. She shared a quote by Jim Womack of the Lean Enterprise Institute, which states:

> "Just as a carpenter needs a vision of what to build in order to get the full benefit of a hammer, Lean Thinkers need a vision before picking up our Lean tools. Thinking deeply about purpose, process, and people is the key to doing this."
>
> Jim Womack, Lean Enterprise Institute

Ms. Omi reviewed the Breakthrough enterprise-wide improvement system matrix (presentation slide #14) that highlighted the Hoshin Kanri tool which was used to identify and align strategic priorities. Ms. Omi described how HHC's strategic priorities were cascaded to the Networks and facilities through the use of the Hoshin Kanri tool.

Ms. Omi reported that the daily management system (DMS) was the second largest body of work that was being undertaken through Breakthrough. She described DMS as a system for identifying work site goals and managing performance for these goals. This is done through the engagement of staff and managers in real-time data collection and review; and the application of problem solving tactics to remove obstacles and continuously improve performance.

Ms. Omi explained that DMS is a foundational component of Breakthrough and DMS:

- Uses Breakthrough tools and concepts (i.e., root cause analysis, visual management, managing through data etc.)
- Eliminates waste and process variation
- Is the Gemba manifestation of Hoshin Kanri initiatives
- Engages all workers in the Gemba
- Includes processes for problem escalation and resolution through active participation of managers and leaders

Ms. Omi highlighted the work of the Kings County Hospital's Adult Primary Care DMS team. She explained that DMS tools were being deployed because:

- There are major challenges to be addressed in the foreseeable future.
- HHC is ready to pull in more challenging tools and DMS requires great discipline.
- Improvements achieved through events are difficult to sustain absent 'glue' between events.
- Absent a system to embed a culture of continuous improvement, HHC risks plateauing its improvement development.
- It will take HHC many more years before all staff has the opportunity to participate in events.
- It provides another venue for broad staff engagement.

Ms. Omi stated that presentation slide #18 titled, "Why both RIEs and DMS?" was the most important slide because HHC expected to achieve Breakthrough improvements through rapid improvement events but, in the absence of a management system, degradation of those improvements would occur. Combined, HHC will achieve continuous incremental improvement punctuated with stair-step breakthroughs.

Ms. Omi presented the tenets of Lean/Toyota Production System, which included the following:

- The Customer Defines Value
- Deliver Value to Customers on Demand
- Standardize and Solve to Improve
- Mutual Respect and Shared Responsibility Enable Higher Performance
- Transformational Learning Requires Deep Personal Experience

Ms. Omi identified the eight wastes in health care, which are:

1. Overproducing
2. Transporting
3. Defects
4. Waiting
5. Over Processing
6. Unnecessary Motions
7. Inventory

8. Unused Human Potential

Ms. Omi reported on the major planning and improvement tools used as part of the Breakthrough improvement system. They include:

- Hoshin kanri (strategy deployment)
- Value Stream Analysis
- Vertical Value Stream Mapping
- Rapid Improvement Events
- 2P (Process Preparation)
- Daily Management System

Ms. Omi explained that the planning improvement tools do not work alone. They work with a number of adjunctive tools, which include:

- Four-track training program
  - Breakthrough experts
  - General awareness
  - Managers
  - Executive leadership
- Breakthrough Development Initiative
  - Go see what good looks like (external gemba visits, continuing education)
- Communication
  - Annual conference
  - B-Blasts
  - Newsletters
  - Report-outs
  - Integrate into operations, i.e., quality improvement, councils, town hall meetings, executive staff meetings

Ms. Omi reported on the different tools and processes used to sustain Breakthrough's benefits. The following tools are used to manage, monitor, and sustain PDCA at all levels:

- Process Control Boards
- Site and value stream steering teams
- Enterprise Steering Committee
- Daily Management System
- Transformation Plan of Care (TPOC) reviews

Ms. Omi described the Breakthrough training program. The goal of the training program is to help employees to:

- Understand waste
- Develop A3 thinking and problem solving skills
- Begin to use value stream thinking
- Develop Lean leadership and strategy

Ms. Omi explained that all employees are required to take the Breakthrough Awareness and the Green Level training classes. Other Breakthrough training courses that are available to HHC employees include:

- Platinum Training (Strategic Execution)
- Gold training (Lean leadership and advanced tools)
- Silver Training (How to create Model Value Streams)
- Silver Training (How to create Model Value Streams)
- Bronze Training (A3 problem solving and using the tools for DMS)
- BMS: Process Owner (Owning RIE support a team, use DMS)

Ms. Omi described HHC's expectations regarding the implementation of the Breakthrough improvement system. These expectations include that HHC would learn from external experts (Simpler) but would build internal expertise deep and wide. HHC would be able to broadly define its return on investment and measure its successes using a balanced score card (True North Metrics). These expectations also include the development of a new way of doing business; a staff empowered to change how the work is done; leaders serving as coaches; and a system of staff engagement at all levels.

Ms. Omi stated that, while the Corporation had not met all the expectations, it was important to note that, as of April 2013, a total of 1,299 rapid improvement events had been completed. She highlighted that, if it were not for Hurricane Sandy, which caused the closure of three HHC facilities that had been actively involved in rapid improvement events; HHC would have achieved the projected number of events by the end of the fiscal year. As a result, the projected number of RIEs will be 55 less than what had been projected. Ms. Omi also reported that, while employee participation in events and training had also increased, the goal was to double that rate of increase every year.

Ms. Omi reported that HHC had achieved a combined total of $317.24 million in cumulative revenue and cost savings from the inception of Breakthrough through April 30, 2013. The combined revenue and cost savings achievements from FY 08 through FY 13 are provided below:

- FY08 = $ 0.38 million
- FY09 = $19.77 million
- FY10 = $89.35 million
- FY11 = $92.87 million
- FY12 = $55.59 million
- FY13 = $69.30 million

Ms. Omi noted that the $317.24 million does not include indirect benefits (i.e., increases in productivity), which enable maintenance of services despite a reduced workforce (through attrition without backfilling). Ms. Omi informed the Committee that, for every contract dollar authorized; HHC had identified an average of $17.52 in financial benefit. She explained that, by the end of this current contract period in October 2013; HHC would have spent $20.5 million on an anticipated $357 million in financial benefit. This holds true to the benefit/$1 invested of $17.52/$1ratio.

Ms. Omi reported on Breakthrough training accomplishments. She stated that, to date, a total of 2,613 staff members have participated in Breakthrough training. A total of:

- 12 Platinum Pending
- 1 Platinum Certified
- 13 Gold Certified
- 19 Gold Pending
- 38 Silver Pending
- 51 Silver Certified
- 130 Bronze Certified
- 191 Bronze Pending
- 1,920 Green Certified

Ms. Omi stated the Green Level Training continued to roll out across the entire Corporation. She explained that Green Training is a one day long training which provided a background and an overview of Lean and served as an entry level course on A3 thinking. In addition, a 90-minute on-line Breakthrough awareness course is available. She noted that several thousand employees had already taken that course just at the beginning of the fiscal year.

Ms. Omi reported on the daily management system (DMS) achievements at four sites from March 2013 to May 2013. The results are the following:

1. Woodhull Medical and Mental Health Center/North Brooklyn Health Network:
   - Closed visits by end of day at 97%
   - Appointment "Reminder Call' increase to 69%
   - Patients seeing their own Provider from 65% to 96%
   - Press Gainey mean scores up between 6% to 19.5%
   - Press Gainey Top Box Scores up between 15% to 44.4%

2. Metropolitan Hospital Center:
   - Patient discharge by 2PM rates up 6%
   - Completion of patient discharge documentation ($) up 15%
   - Post D/C appointments within 7 days up 16%
   - Press Gainey Top Box scores up 24%
   - Press Gainey hospital recommendations up 10%
   - Press Gainey nurse communications up 24%

3. Kings County Hospital:
   - Patients seen at appointment time up from 21% to 62%
   - RIE participation up 25% over goal (42%)
   - Percent of visits closed by end of day from 50% to 100%

4. Lincoln Medical and Mental Health Center:
   - Open visits <2 days down from 811 to under 80
   - Patient satisfaction questionnaire rating of 5 - at 65%
   - Patients planning to deliver at Lincoln from 60% to 67%
   - Number of walk-in Patients from 20/day to under 6/day

Ms. Omi highlighted other successful DMS applications including:

- Reduced patient wait time from 57 minutes to 24 minutes at Lincoln Medical and Mental Health Center's Immunology Clinic
- 45% drop in Telemetry Alarms at Elmhurst Hospital Center
- Reduction of cycle time for cast patients in Orthopedic Services at Elmhurst Hospital Center
- OR utilization with turnover at Queens Hospital Center
- Improve delays and cancelation of surgeries at Bellevue Hospital
- Enforce the discharge of patients over the weekend to meet the demand of Kings County Hospital Center's Emergency Department
- Improvement of charts documentation and coding in the surgery clinic at Harlem Hospital Center
- Redesign of the ED Admission Process at Coney Island Hospital
- Ensure that morning routine lab results are available by 8:30 a.m. so that clinical staff can effectively plan patient care at Woodhull Medical and Mental Health Center

Ms. Omi presented the projected Fiscal Year 2014 training plan to the Committee. This training plan is provided below:

Breakthrough Training Plan for Fiscal Year 2014

	Elements	Objectives
Embed learning opportunities in support of organizational transformation	Daily Management System	• Engage staff and managers in daily improvement through empowered problem solving
	Model Value Streams	• Create learning laboratories/test environments of 'what good looks like'
	Infrastructure	• Enable he building blocks of a stable and sustained system of improvement
	Spread	• Teach and share the means of rapidly spreading what works

	Objectives
Ensure relevance to ongoing and strategic needs	• Closely align ongoing and spot training to business goals, i.e., psychiatric LOS reduction, deficit reduction
	• Develop Leadership Training
	• Continue to increase access for Bronze and Silver Trainings
	• Develop cadre of Platinum-certified internal consultants
	• Develop growth pathways for Breakthrough trainees
	• Provide CMEs for clinicians

Ms. Omi discussed developing internal capacity for the large scale spread of DMS. She stated that, four areas – three outpatient clinics and one med/surg unit – were currently being tested as a model for the approach, application, and training for DMS. Since the model was established in February, it is continuously being assessed and improved upon before it is rolled out to additional facilities. By July 1, 2013, HHC will begin to expand the number of areas learning to implement DMS within the original test sites, and will identify four additional facilities to initiate DMS within specific service areas. By December and every 4-6 months thereafter, the number of areas using DMS will increase. The goal is to have DMS initiated at a total of 244 areas by the end of Fiscal Year 2016. Ms. Omi explained that HHC will accomplish this large spread by "teaching as we go," so that trained leaders at each site will then train additional staff members, while HHC continues to use internal and external experts to launch DMS at wholly new sites.

Ms. Omi reported on the plan for the Breakthrough improvement initiative going forward. She stated that:

- HHC needs consultant time longer than planned to continue to meet growing demand and embed learning/transfer technology to sites. Some of this is due to:
    - HHC's own stumbling
    - HHC's initial ignorance of what this would take
- Consultants will have a diminishing role but HHC will likely need some ongoing monitoring/coaching from an external agent
- Staffing model will continue to evolve
    - Estimate another 5-10 dedicated staff needed, but
    - This could be a significant underestimate depending on timing, emerging business needs, depth and breadth of applications
    - Developing 'embedded facilitator/trainers'
- Training program to focus on real-time training, emerging business needs (flexibility and anticipation)
        - Role of trained people in the organization
        - Retention and succession planning
        - Continually improving certification program
        - Leadership development
- Role of enterprise and site Breakthrough offices must continue to evolve
- Spread of the daily management system

- Spread of model value streams
- Greater alignment of effort and focus across the enterprise
- Go deeper: kata, training within industry
- Continued exploration – there is much we still don't know and much we can improve

Dr. Stocker thanked Ms. Omi for her presentation. He commented that Breakthrough is very impressive and would change the Corporation forever, like the electronic medical record (EMR). Ms. Omi responded that it takes a village.

Mrs. Bolus asked if the Corporation's achievements would ever be self-sustainable. Ms. Omi responded that it could be but it would be HHC's choice. However, she cautioned that past experiences from other Lean organizations like Bellwether Services show that it would be very difficult to accomplish on their own. In addition, Ms. Omi stated that some non-healthcare organizations have kept Lean consultants on board for a longer period of time. She noted that self-sustainment results were unpredictable. Some organizations are capable to sustain their achievements over decades while other organizations have been unable to sustain those achievements when faced with change of leadership. Ms. Omi stated that it would be beneficial to have a consultant come back once in a while to challenge HHC and to help HHC really think beyond its current paradigm and to push HHC to do much more. Ms. Omi concluded her presentation by stating that the Corporation still needs some assistance to get through some of the mechanics and with the anticipated reduction in the contract over the next few years, HHC is taking very seriously the need and the desire to embed Breakthrough internally.

Mrs. Bolus thanked Ms. Omi for her presentation.

ADJOURNMENT

There being no further business, the meeting was adjourned at 11:15 a.m.

2013 New York State Legislative Session

2013 Statistics

- ✓ 13,994 bills introduced
- ✓ 758 bills passed Senate only
- ✓ 421 bills passed Assembly only
- ✓ 349 bills passed both houses
- ✓ HHC actively tracking 924 bills

Staffing Ratios

S.3691-A (Hannon)/A.6571 (Gottfried)

- Imposes mandatory nurse staffing ratios for hospitals and nursing homes.
- Would require HHC to hire 3,200 new nurses costing more than $388 million just for hospitals
- HHC Opposed
- **Did not pass EITHER house**

Safe Patient Handling

S.1123-A (Maziarz)/A.2180-A (Gunther)

- Requires hospitals and nursing homes to implement new policies with specific staffing, technology and equipment requirements
- Allows nurses to refuse to handle patients if they believe it inconsistent with new policy
- HHC Opposed
- **Passed Assembly ONLY**

Medical Malpractice

S.744 (Fuschillo)/A.3564 (Weinstein)

- Extends New York's statute of limitations from thirty months from the date of the alleged malpractice, to thirty months from whenever the alleged malpractice is discovered
- HHC Opposed
- **Did not Pass EITHER House**

SUNY Downstate

S. 5902 (Rules) and A.8066 (Perry)

- Governor proposed bill to create Brooklyn Health Improvement Corporation, which would receive Delivery System Reform Incentive Payment funds
- Senate introduced revised version of Governor's bill
- Assembly introduced bill based on organized labor's recommendations
- HHC advocated to preserve affiliation agreement and DSH funding
- **Did not pass EITHER house**

Job Order Contracts

S.3564-A (Bonacic) / A.4810-A (Abbate)

- Would limit use of job order contracts
- Allows for exceptions for work needed due to Hurricane Sandy or future State Disaster Emergencies
- HHC Opposed
- **Passed BOTH Houses**

New Hospital Requirements

- Three bills would mandate new screening exams for hospital patients:

✓ Hepatitis-C (Hannon/Zebrowski)

✓ Pulse Oximetry for newborns (Hannon/Gunther)

✓ Maternal Depression (Krueger/Gottfried)

- Another bill would require patient notice when in Observation Unit (Hannon/Peoples-Stokes)

- **All bills Passed BOTH Houses**

Professional Licensing

- Several bills would impose new licensing requirements for health care professionals:

✓ Clinical Nurse Specialists (Kreuger/Lifton)
✓ Surgical Technologists (Savino/Cahill)
✓ Central Service Technicians (Grisanti/Bronson)
✓ Dental Hygienists (Hannon/Glick)
✓ Pharmacist meningitis vaccine (Hoylman/O'Donnell)

- **All bills Passed BOTH Houses**

Managed Long Term Care

S.3812 (Hannon)/A.7636 (Gottfried)

- Creates new requirements for transitioning patients to managed long term care (MTLC)
- Patients must have choice of plans, receive enrollment assistance, be notified of rights & options
- Plans must provide consumer assistance and complaint process
- SDOH to report on quality including network adequacy
- **Passed BOTH Houses**

HHC Specific Legislation

S.2474 (Lanza)/A.130 (Cusick)

- Requires HHC to spend 10% of Operating Budget on Staten Island ($670 million)
- **Passed Senate ONLY**

S.2481 (Lanza)/A.135 (Cusick)

- Requires HHC to finance the operation of at least 2 Emergency Departments on Staten Island
- **Did not pass EITHER House**

Other Issues

- Several issues that had been considered during the State Budget process were introduced
- ✓ Certificate of Need (CON) Review (Gottfried)
- ✓ Health Care Facility Access to Capital (Hannon)
- ✓ Licensing Limited Services Clinics (Paulin/Hannon)

- **Bills did not pass EITHER House**