

**STRATEGIC PLANNING COMMITTEE MEETING  
OF THE BOARD OF DIRECTORS**

**JULY 8, 2014  
10:00 A.M.  
HHC BOARD ROOM  
125 WORTH STREET**

**AGENDA**

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

**II. ADOPTION OF JUNE 10, 2014  
STRATEGIC PLANNING COMMITTEE MEETING MINUTES** **JOSEPHINE BOLUS, RN**

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

**IV. INFORMATION ITEM:**

**i. 2014 NEW YORK STATE LEGISLATIVE SESSION UPDATE PRESENTATION**

WENDY SAUNDERS, ASSISTANT VICE PRESIDENT  
OFFICE OF INTERGOVERNMENTAL RELATIONS

**V. ACTION ITEM:**

AUTHORIZING THE PRESIDENT OF THE NEW YORK CITY HEALTH AND HOSPITALS CORPORATION (THE "CORPORATION") TO NEGOTIATE AND EXECUTE A CONTRACT WITH SIMPLER NORTH AMERICA, LLC ("SIMPLER") TO PROVIDE "LEAN" COACHING, CONSULTATION AND TRAINING SERVICES IN SUPPORT OF THE FURTHER IMPLEMENTATION OF BREAKTHROUGH THROUGHOUT THE CORPORATION, AS WELL AS FOR THE ACCELERATION OF INDEPENDENCE FROM OUTSIDE EXPERTISE. THIS CONTRACT SHALL BE FOR A TOTAL AMOUNT NOT TO EXCEED \$10,494,000 FOR THE PERIOD FROM NOVEMBER 1, 2014 THROUGH OCTOBER 31, 2017, WITH TWO ONE-YEAR OPTIONS FOR RENEWAL, SOLELY EXERCISABLE BY THE CORPORATION, SUBJECT TO ADDITIONAL FUNDING APPROVAL BY THE CORPORATION'S BOARD OF DIRECTORS (EEO APPROVAL RECEIVED; VENDEX APPROVAL PENDING)

JOANNA OMI, CHIEF INNOVATION OFFICER/SENIOR VICE PRESIDENT  
DIVISION OF ORGANIZATIONAL INNOVATION AND EFFECTIVENESS

**VI. OLD BUSINESS**

**VII. NEW BUSINESS**

**VIII. ADJOURNMENT**

**JOSEPHINE BOLUS, RN**

## **MINUTES**

### **STRATEGIC PLANNING COMMITTEE MEETING OF THE BOARD OF DIRECTORS**

**JUNE 10, 2014**

The meeting of the Strategic Planning Committee of the Board of Directors was held on June 10, 2014 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  
Ram Raju, M.D.  
Anna Kril  
Robert F. Nolan  
Bernard Rosen  
Patsy Yang, representing Deputy Mayor Lillian Barrios-Paoli

##### **OTHER ATTENDEES**

J. DeGeorge, Analyst, New York State Comptroller  
M. Dolan, Senior Assistant Director, DC 37  
C. Fiorentini, Analyst, New York City Independent Budget Office  
D. Woodrooffe, Analyst, Office of Management and Budget

##### **HHC STAFF**

M. Belizaire, Assistant Director of Community Affairs, Office of Intergovernmental Relations  
J. Bender, Assistant Director, Media Relations, Communications and Marketing  
C. Barrow, Assistant Director, Lincoln Medical and Mental Health Center  
L. Brown, Senior Vice President, Corporate Planning, Community Health and Intergovernmental Relations  
T. Carlisle, Associate Executive Director,  
L. Cassaldo, Senior Finance Analyst, MetroPlus Health Plan  
D. Cates, Chief of Staff, Office of the Chairman  
A. Divittis, Associate Director of Grants, Woodhull Medical and Mental Health Center

M. Dunn, EEO Officer, North Bronx Health Network  
L. Guttman, Assistant Vice President, Office of Intergovernmental Relations  
L. Haynes, Assistant Systems Analyst, President's Office  
N. Holder, Intern, Corporate Planning Services  
L. Johnston, Senior Assistant Vice President, Medical and Professional Affairs  
J. Jurenko, Senior Assistant Vice President, Office of Intergovernmental Relations  
Z. Liu, Senior Management Consultant, Corporate Planning Services  
P. Lockhart, Secretary to the Corporation, Office of the Chairman  
P. Lok, Director, Corporate Finance  
K. Madej, Director of Social Media, Communications and Marketing  
A. Marengo, Senior Vice President, Communications and Marketing  
H. Mason, Deputy Executive Director, Kings County Hospital Center  
A. Martin, Executive Vice President and Chief Operating Officer, President's Office  
M. Norris, MD, MBA, Director of Care/Case Management, Queens Health Network  
K. Olson, Assistant Vice President, Corporate Budget  
J. Omi, Senior Vice President, Organizational Innovation and Effectiveness  
M. Pakala, Intern, Corporate Finance  
S. Penn, Deputy Director, World Trade Center Environmental Health Center  
C. Philippou, Assistant Director, Corporate Planning Services  
S. Russo, Senior Vice President and General Counsel, Office of Legal Affairs  
W. Saunders, Assistant Vice President, Office of Intergovernmental Relations  
N. Stine, Chief Medical Officer, HHC Accountable Care Organization  
D. Thornhill, Associate Executive Director, Strategic Planning, Harlem Hospital Center  
J. Wale, Senior Assistant Vice President, Behavioral Health  
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 10:32 a.m. by the Strategic Planning Committee Chairperson, Josephine Bolus, NP-BC. The minutes of the May 13, 2014 meeting of the Strategic Planning Committee were adopted.

## SENIOR VICE PRESIDENT REMARKS

### State Update

#### 2014 State Legislative Session Draws to a Close

Ms. Brown began her remarks by informing the Committee that the New York State Legislature would be concluding its 2014 Legislative Session on June 19, 2014. Ms. Brown also informed the Committee that with the increasing level of legislative activities in Albany, HHC's Intergovernmental Relations staff would be closely monitoring several proposals that could significantly impact the corporation. These proposals include:

- **Job Order Contracts:** Job Order Contracts (JOCs) streamline the administrative process of designing, engineering and contracting of multiple projects and cuts down on administrative costs associated with procurement. HHC uses JOCs for renovation, repair and maintenance projects in situations where traditional contracting would be impractical. Ms. Brown explained that, last year, Governor Cuomo had vetoed legislation that would have prohibited the use of JOCs. She added that this year the Legislature was poised to pass a revised proposal that would prevent the use of JOCs except in very limited circumstances.
- **Staffing Ratios:** The Assembly has moved legislation that would impose mandatory nurse staffing ratios for hospitals and nursing homes. Ms. Brown reported that the Senate had not moved on this legislation. Ms. Brown reminded the Committee that if the staffing ratios legislation were to be implemented, it would have required HHC to hire 3,800 new nurses, at a cost of more than \$388 million just for the acute care hospitals.
- **Medical Malpractice:** There are several bills that would alter the rules governing medical malpractice. At this stage, proponents appear to be focusing their efforts on legislation that would extend the statute of limitations from 30 months from the date of the alleged malpractice to 30 months from when the alleged malpractice is discovered.

Ms. Brown stated that she would keep the Committee apprised of the status of those proposals and other legislation that would have an impact on HHC. She announced that Ms. Wendy Saunders, Assistant Vice President of the Office of Intergovernmental Relations would provide the Committee with an update on key legislative activities at the close of the session at the July Committee meeting.

### City Update

#### HHC Testifies at Executive Budget Hearing

Ms. Brown reported that Mr. Ram Raju, M.D., HHC's President, provided testimony before the City Council Finance, Health and Mental Health Committees late last month. She informed the Committee that, in his testimony, Dr. Raju highlighted key HHC priorities including the need to reduce healthcare disparities and HHC's priority to create and/or expand partnerships to better coordinate and improve access to care with a focus on being inclusionary rather than exclusionary. Ms. Brown informed the Committee that Councilmembers inquired about:

- HHC's budget deficit and risks to the financial plan
- HHC's plans for the new 1115 Medicaid Waiver
- HHC's labor contracts
- Status of HHC's dialysis proposal
- HHC's efforts to increase Hepatitis testing and treatment
- HHC's future plans for outsourcing or privatization

Ms. Brown reported that Dr. Raju's response to the question concerning the outsourcing of dialysis services received the most attention. She informed the Committee that Dr. Raju's response was that the implementation of dialysis outsourcing would be postponed until some future time.

Ms. Brown reported that the Council concluded its series of budget hearings on June 6, 2014. She commented that the hearing lasted late through the day. She informed the Committee that two Community Advisory Board (CAB) members, Ms. Queenie Huling, CAB Chair of Coney Island Hospital and Ms. Agnes Abraham, Chairperson of the Council of CABs and Chairperson of the Kings County Hospital Center's CAB had provided testimony at the budget hearing on behalf of all of HHC's Community Advisory Boards. Ms. Brown noted that it was impressive when HHC's CAB members and consumers stay for the long haul to make their concerns and their support of HHC known.

Dr. Ram Raju, HHC's President, acknowledged Ms. LaRay Brown, Senior Vice President and her team for their incredible work in putting together the Delivery System Reform Incentive (DSRIP) and the Interim Access Assurance Fund (IAAF) applications in collaboration with HHC's Finance Department. Dr. Raju added that these staff members had worked very hard and worked very late over several nights to put together very good applications. He also informed the Committee that for the first round, HHC received more than 70% of the IAAF funding and it was HHC's hope that this trend would continue. Dr. Raju added that this achievement demonstrated how strong the application was and how hard the staff had worked to prepare these applications within a very short timeframe. Ms. Brown thanked Dr. Raju for his acknowledgement. She acknowledged Mrs. Zurack and Ms. Dona Green and the Corporate Planning/HIV Services unit team for their hard work in meeting the applications' deadlines. She commented that, "It takes a village."

## **INFORMATION ITEM**

### **ED Care Management Initiative: Preventing Avoidable ED/Inpatient Use**

Anthony Divittis, Associate Director of Grants, Woodhull Medical and Mental Health Center  
Marlaina Norris, MD, MBA, Director of Care/Case Management, Queens Health Network

Ms. Brown introduced and invited Mr. Anthony Divittis, Associate Director of Grants, Woodhull Medical and Mental Health Center and Ms. Marlaina Norris, MD, Director of Care, Case Management, Queens Health Network to present the ED Care Management Initiative: Preventing Avoidable ED/Inpatient Use. Ms. Brown informed the Committee that, on May 21, 2014, HHC was notified by the Centers for Medicare and Medicaid

Services (CMS) that it was a recipient of its CMMI Round II Innovations Grant. She explained that this grant award was extremely important to HHC because it would enable HHC to enhance and expand upon a pilot program that HHC had initiated several years ago in its Emergency Departments (EDs) across the corporation. Ms. Brown informed the Committee that HHC had initially requested a larger amount of funding than was eventually awarded. Ms. Brown acknowledged the two presenters Mr. Divittis and Dr. Norris along with other HHC staff had worked to prepare and submit the grant application. Ms. Brown informed the Committee that the team included Central Office and facility staff who worked over the course of several weeks via conference calls, in person meeting and late into the night to ensure that HHC's CMMI Round II grant application was completed and submitted in a timely manner. Team members include Martin Castaneda, Associate Director of Administration,, Anita Lee, Associate Director, Grants and Contracts, Krista Olson, Deputy Budget Director; Mahendra Patel, Senior Director, Grants Management, Christopher Philippou, Assistant Director of Planning, Ms. Wendy Saunders, Assistant Vice President of Intergovernmental Relations, Mr. Mark Winiarski, Assistant Director of Planning, and Ms. Kathleen Whyte, Senior Director of Corporate Planning. Ms. Brown reported that HHC's grant award was \$17.9 million. Ms. Brown invited Mr. Divittis and Dr. Norris to present the grant funded program to the Committee.

Dr. Norris thanked Ms. Brown and Committee Members for the opportunity to present the ED Care Management Initiative. She began her presentation with a description of the CMS Health Care Innovation Awards Round Two Funding opportunity. She reported that, on May 15, 2013, CMS had announced the CMMI Round II Health Care Innovations grant funding opportunity. A Letter of Intent (LOI) was due on June 28, 2013, with a final application submission due date on August 15, 2013. Dr. Norris explained that the purpose of the grant opportunity was to fund new payment and service delivery models and to reduce Medicaid spending. Dr. Norris clarified that a service delivery model, as defined by CMS, referred to how providers organize and deliver care to patients. She explained that a payment model referred to how the Medicare, Medicaid, or CHIP programs pay providers to provide an incentive in the provision of efficient and high quality care. Dr. Norris informed the Committee that HHC applied within the innovations category for models that test approaches for specific types of providers to transform their financial and clinical models. This is a model to test a specific care structure that is attached to a newly developed financial model.

Dr. Norris reported that CMS had announced that there would be \$900 million in funding available and that the awards would range from \$1 million to a maximum of \$30 million. In addition, grant funds would be provided over a period of three years (April 2014 – March 2017). Dr. Norris stated that CMS had officially announced the first batch of prospective recipients for the Health Care Innovation Awards Round Two funding on May 22, 2014. HHC was included in the first round of announcements and HHC would receive \$17,916,663 over three years. Dr. Norris reported that there were 12 national contract awards in this phase and that other awardees would be announced over the summer. She noted that contractual agreements would ensue following the second round of funding announcements.

Dr. Norris described HHC's pilot ED Care Management Program. She reported that the ED Care Management Program was launched in 2008 with pilot initiatives explored at Elmhurst, Bellevue, and Queens Hospitals. Dr. Norris explained that the goals of these independent trials were to:

- Expand patient care coordination and move it earlier to the front door at the beginning of the patient admission process. As an example, Dr. Norris explained that, before diabetic patients could be admitted, these patients would need to know how to self-administer their finger sticks, how to take their insulin medication by themselves, and how to control their condition through diet. As such, it is beneficial for the Emergency Departments (EDs) to be staffed with a patient care coordinator whose role would be to educate patients in that process.

- Arrange and coordinate with a patient care coordinator to check on the patients after they were discharged
- Partner more with patients to decrease unnecessary ED utilization and develop ways to decrease admissions for these types of conditions
- Provide care and case management services to targeted patient population
- Use an interdisciplinary team to facilitate and coordinate care for patients who can be safely treated and released

Dr. Norris reported that the Agency of Healthcare Research and Quality (AHRQ) had identified prevention quality indicators (PQIs), which are a set of measures that could be analyzed along with hospital inpatient discharge data to identify quality of care for "ambulatory care sensitive conditions" (ACSCs). These conditions include:

- Skin infections
- Chronic Heart Failure (CHF) or Cardiomyopathy
- Asthma/COPD
- Hypertension
- Diabetes
- Pneumonia

Dr. Norris explained that the need for hospitalization for patients who present to the EDs with ACSCs and for those patients who returned to the EDs within 30 days of inpatient discharge would have been avoided or potentially prevented if those patients had received the education needed for appropriate self-management and had a stronger connection to primary care. Dr. Norris stated that it was decided that more should be done to get patients more engaged in their health maintenance. Dr. Norris informed the Committee that both MetroPlus and Health First Health Plans had begun to track PQIs across all HHC facilities.

D. Norris described the key care management activities of HHC's pilot ED Care Management Program, which included the following:

- Identify avoidable admissions
- Implementation of a Team STEPPS communication model
- Assess patients and determine needs
- Connect patients into primary care services (Medical Home)
- Educate and engage patients on the importance of maintaining their health, medication adherence and aid patients with navigating the health care system
- Provide appropriate alternative options to hospitalization
- Align with IHI Triple AIM and HHC's Road Ahead program

Dr. Norris reported that, in 2012, under the guidance of the former Senior Vice President for the Queens Health Network, Ms. Ann Marie Sullivan, M.D., a Breakthrough project was initiated involving at least two staff members from every acute care facility to share some of the pilot experiences and to roll-out the ED Care Management Program. The Breakthrough project focused on standard work, the promotion of enterprise-wide collaboration and sharing of best practices. Dr. Norris added that, with the support of HHC's leadership staff, in 2012, the ED Care Management Program was expanded across all acute care facilities with a funding commitment of \$15 million. The funding commitment provided each acute care facility with the opportunity to expand their staffing model to include the following staff complement:

- 0.5 FTE ED Physician Advisor
- FTE ED Care Manager (to provide patient bed education)



- FTE ED Case Manager (to help improve emergency department documentation)

The physician advisor, care and case managers work with other team members including social workers, extenders and residents to educate both patients and staff. Dr. Norris commented that HHC's \$15 million investment added credibility to HHC's CMMI grant application as it demonstrated HHC's commitment to the ED Care Management program.

Dr. Norris reported that, between January 2012 and December 2013, HHC's ED Care Management program had provided services to a total of 26,698 cases. By the end of 2012, every facility had at least one shift of coverage of the ED Care Management Program. Of the 26,698 cases, 12,909 or roughly half of the cases had ambulatory care sensitive conditions (ACSCs). She highlighted some program outcomes, which are described in the chart below:

*Table 4: Evaluation of Pilot ED Care Management Results from 3 HHC Hospitals*

	<b>Woodhull Medical and Mental Health Center</b>	<b>Coney Island Hospital Center</b>	<b>Lincoln Medical and Mental Health Center</b>
<b>Intervention Period</b>	<i>3 months</i>	<i>15 months</i>	<i>4 months</i>
<b>% kept PCP appointment post intervention</b>	Increased from 30.7% to 44.1%	Increased from 21.1% to 32.8%	Increased from 70.8% to 81.5%
<b>% of ED visits within 7 days post intervention</b>	Reduced from 21.2% to 8.3%	Reduced from 10.5% to 8%	Reduced from 20.8% to 12%
<b>% of admission within 30 days post intervention</b>	Reduced from 19% to 14.3%	Reduced from 9.1% to 5.6%	Reduced from 4.2% to 1.1%

Dr. Norris explained that, as a result of the ED Care Management Program, the percentages of kept primary care physicians' appointments (PCP) were increasing. She noted that, while many of the patients hadn't known the value of primary care prior to the initiative, they had begun to appreciate the program as the team continued to work on it and encourage it. Dr. Norris further noted that, within seven days of implementing the ED Care Management Program at Woodhull Medical and Mental Health Center, ED visits was reduced from 21.2% to 8.3%. The ED Care Management team was able to identify the education gaps at the onset of the encounter and to determine what resources would be needed in order to coordinate and sustain a safe discharge.

Dr. Norris reported that HHC's initial funding request to CMS was for a total of \$28 million to expand the program with some enhancements at all HHC hospitals and to address the following gaps:

- Lack of medication management/adherence
- Need for better linkages to home care
- Need for better coordination with community provider
- Need for improved and extended follow-up with patient at home (48 to 70 hours after discharge to ensure that they are linked to PCP and keep connection for over a week)
- Need for more robust data collection/analysis

Dr. Norris also reported that HHC's grant application in response to the funding opportunity included a proposed payment model.

Mr. Divittis continued the presentation by providing an overview of HHC's proposal to CMS. He explained that the aim was to respond to CMS' requirement of reducing Medicaid spending by \$75 million and to create an infrastructure that would support the sustainability and enhancement of the pilot program across the acute care facilities. The proposed program also focused on successfully preventing avoidable hospitalizations and readmissions as well as reducing unnecessary ED visits and revisits of patients with ambulatory care sensitive conditions (ACSCs). In essence, HHC's proposed program/demonstration project would show a successful way of managing ACSCs.

Mr. Divittis reported that HHC's initial proposal of \$28 million for all 11 HHC hospitals was to operate seven days per week, with on-site care management teams covering two shifts. Services would be enhanced by adding:

- Full-time Physician Advisor Team Leader (instead of part time)
- Community Service Liaison Worker (CLW) who would follow the patients for up to 90 days after their ED visits ensuring that they are linked to primary care; and to help address mitigating issues should the patients have additional issues or barriers.
- Clinical Pharmacist to help with education and treatment adherence including issues of health literacy which come with management of medication for these conditions
- On-site Home Care Intake Nurse and follow-up
- Social Workers and other clinical staff available to the ED would be involved when appropriate
- Capacity for sophisticated analysis
- Strong centralized leadership support and a uniform program across all 11 facilities

Mr. Divittis reported that, in order to sustain the program beyond the funding period, applicants were also charged with designing an innovative payment model. He described the three components of this model as the following:

- HHC's application highlighted its existing risk arrangements with MetroPlus and Health First Health Plans, which already allowed savings from reduced healthcare expenditures to flow back to HHC.
- The State Department of Health has committed to working with HHC to develop a new payment model for Medicaid Fee-For-Service, particularly focused on Emergency Medicaid. Reducing hospitalizations and ED visits will not become a disincentive. There would be a way of generating a new stream of revenues.
- HHC secured letters of commitment from two commercial plans that currently pay on a fee for service basis to explore value-based reimbursement models.

Ms. Brown informed the Committee that Empire Blue Cross Blue Shield and Aetna Health Plan were the two commercial health insurers that would explore the value-based reimbursement models with HHC over the three year period. Mr. Divittis informed the Committee that overall, the targeted reductions in avoidable admissions would result in a net decrease of \$75 million in Medicaid expenditures over the three years.

Mr. Divittis reported that, because the ED Care Management initiative would be a demonstration project, the program would require a strong evaluation plan. To that end, independent evaluators will be contracted to create an evaluation plan to assess the impact of the standardized program across six HHC sites. Mr. Divittis explained that, while the original proposal was to roll out the ED Care Management Program to all 11 acute facilities, it was scaled back due to CMS' recommendation to only include six facilities. Mr. Divittis reported that a CMS Coordinating Center would also assist with finalizing the selection of variables that "operationalize" improved healthcare and cost savings. Mr. Divittis noted that CMS was highly invested in this project and would have an oversight role in HHC's program. Mr. Divittis informed the Committee that

from time to time evaluators will statistically compare the grant funded program with several similar groups to determine the following:

- Did the enhanced program achieve clinical goals of improving healthcare?
- Did the enhanced program achieve the financial goal of cost savings and sustainability?

Mr. Divittis reported that HHC's evaluation tasks would include:

- Setting up internal systems to collect these data across all groups
- Creating an evaluation plan
- Ensuring that patients' rights are protected
- Collecting valid data and double-checking
- Statistical analyses by independent evaluator

Mr. Divittis reported that in April 2014, CMS recommended that HHC should scale back the program by reducing the number of participating hospitals in the proposal from 11 to 6. The following criteria were used to objectively determine which six HHC facilities would be part of the grant funded program:

1. Percentage of cases with potentially avoidable admissions
  - % of cases in which principal diagnosis is an AHRQ Ambulatory Care Sensitive Case Condition
  - Case with a prior admission within past 30 days
  - Cases with start of home care services
2. Percentage of cases in which patients returned to the ED within 7 days
3. Percentage of cases in which patients returned to the ED within 30 days
4. Percentage of cases that received post-discharge follow-up

Mr. Divittis stated that first criterion helped to determine if there would be a sufficient patient population to draw from, while the remaining three criteria focused on performance during the pilot phase. Ms. Brown clarified and added that HHC wanted to balance both the opportunity for improvement with the grant and also to be successful. Mr. Divittis announced that based on the above criteria, the six HHC facilities that were selected included:

- Bellevue Hospital Center which had high performance on 3 of 4 metrics
- Elmhurst Hospital Center which had high performance on all metrics
- Jacobi Medical Center which had high performance on all metrics
- Kings County Hospital Center which had high performance on 1 of 4 metrics, however Kings had high volume
- Lincoln Medical and Mental Health Center which had high performance on 1 of 4 metrics, but had high volume
- Queens Hospital Center which had high performance on 3 of 4 metrics

Mr. Divittis added that facility selections ensured key geographic coverage for the four boroughs, the potential for reduction in ED use, and offered a mix in baseline outcomes, which will provide the opportunity for health outcomes improvement.

Mr. Divittis described the grant funded program budget as the following:

**Funded Program Budget**

<b>Description</b>	<b>Total</b>
<b>Personnel – 2 Program Management FTE; 36 Clinical FTE</b>	<b>\$15,051,329</b>
<b>OTPS – Includes 2 Contracts (Evaluation; Community Health Worker Training)</b>	<b>\$394,070</b>
<b>Indirect Costs @ 16%</b>	<b>\$2,471,264</b>
<b>Grand Total</b>	<b>\$17,916,663</b>

Mr. Divittis explained that HHC would receive nearly \$18 million in funding over the course of the three year grant funding period. He explained that the vast majority of the funding would cover personnel costs to expand program coverage to two shifts, seven days a week. In addition, it also included central management of two full time positions (FTEs), 36 clinical physicians to be distributed across the six sites. The Other than Personnel Services (OTPS) expenses include general supplies and equipment for the project as well as the management of two contracts. One contract will be for the evaluation of the project. The other contract will be for Community Health Worker Training, which has been proven to be an evidenced-based process. An indirect cost of \$2.5 million is also included in the program's budget.

Mrs. Bolus, Committee Chairperson asked how the grant funded program related to behavioral health. Ms. Brown responded that the location of the staff would be in the non-psych EDs. However, as it has been HHC's experience during the pilot, there would likely be patients with ACSCs and behavioral health needs who present to the EDs. Ms. Brown added that, based on many studies and HHC's recent experiences, many individuals with ACSCs also have the comorbidity of a psychiatric or substance abuse diagnosis. Ms. Brown also noted that some of these patients also have some of the greatest challenges.

Mr. Divittis concluded his presentation by outlining the next steps for implementing the grant funded program. He informed the Committee that after all the awards are announced later this summer, HHC would sign a contract with CMS; hire the staff; enter into a contract with an independent evaluator; and begin a series of internal meetings with key staff and with CMS. Mr. Rosen commented that the pilot study was very important as it made more apparent that additional staff would be needed to carry out the project. He asked if the pilot study had led to the \$18 million CMMI grant award. Ms. Brown clarified that the pilot study provided the basic threshold for HHC to be able to apply. She explained that a key criterion for applying for these innovative funds was past experience in the model that funds were being sought. Based on that experience, HHC's grant proposal described what needs to be done to enhance the model, improve health outcomes and make the deductions in Medicaid expenditures. Ms. Brown commented that the fact that HHC already had this model and had invested \$15 million to spread it from the two facilities in the pilot study to the remaining nine was impressive to CMS. Ms. Brown noted that HHC rarely received grant funding from CMS. However, the fact that HHC had been able to provide credible information about the roll out of this model had helped HHC. Ms. Brown emphasized that the pilot was the threshold.

Mr. Rosen asked about the responsible party for the selection of the independent evaluators. Ms. Brown answered that even though CMS had set the evaluators' criteria, HHC had to identify an evaluator as part of the grant application. This would allow HHC to facilitate the engagement of the evaluator at the onset of the project.

Mrs. Bolus asked if the ED Care Management Project would jeopardize the fact that HHC had to achieve a certain level of staff reductions. Ms. Brown reminded the Committee that, originally the number of staff was reduced to cut the budget due to the lack of resources. However, due to the CMMI grant funding of nearly \$18 million, the addition of 38 staff would be spread across the six facilities (with the exception of two staff that would be at Central Office). She emphasized that the reason for seeking the grant was to ensure that HHC's staffing problem would not be exacerbated by bringing in new people and not having resources at the end of the grant to support them.

Dr. Raju congratulated Ms. Brown and her team for HHC's award of the CMMI Round II funding grant. He added that HHC's goal is to be the leader in transformation not only in New York City but also nationally. He added that the CMMI grant would provide HHC with wider exposure as there were only 12 awardees throughout the country. He added that this achievement was a testament that the federal government is reaching out to change the healthcare delivery system for patients. Dr. Raju noted that, in that regard, HHC had made a difference. He referred to Mrs. Bolus' question about how to sustain the project after the life of the grant and responded that the program would be self-sustaining. He explained that there were penalties for readmissions and the money HHC would pay back (the cost of these penalties) could be reinvested up front for better quality of care while at the same time bringing down the number of readmissions. Dr. Raju asked the Committee to think about the issue globally instead of separately as revenue and expenditures. Dr. Raju added that the CMMI grant award was a great opportunity for HHC and that the program would show its benefits by educating patients and by reducing expenditures. Dr. Raju added that HHC was the only public system that had been awarded this grant. Mrs. Bolus joined Dr. Raju in congratulating Ms. Brown for spearheading the CMMI grant application.

Ms. Brown informed the Committee that, on June 28, 2013, she and Dr. Sullivan had learned about this grant funding opportunity while attending a leadership meeting. The due date for the Letter of Intent (LOI) was 3:00 pm on that very same day. Ms. Brown explained that HHC leadership support was needed to apply for the grant because it would have been risky to undertake a demonstration project with CMS as the project would be visible and placed under scrutiny. The process started with a phone call to Mrs. Whyte and Dr. Norris who pulled together all of the necessary program information and prepared and submitted HHC's Letter of Intent.

Mr. Rosen asked if a readmission after 30 days would result in a penalty. Dr. Raju responded affirmatively. Ms. Brown clarified that a penalty would result if the readmission was for the same condition. Dr. Raju reiterated that, by looking at the evolution of the healthcare system, revenue and expenditures should not be looked at separately but globally.

Mr. Antonio Martin, HHC's Executive Vice President and Chief Operating Officer, congratulated Ms. Brown for her hard work. He asked about the five remaining hospitals that had been excluded from the CMMI grant funded program. Ms. Brown responded that the remaining five hospitals would continue their ED Care Management programs as was described in the staffing model that was presented earlier. She informed the Committee that their work would not dissipate. She added that HHC had identified at least two Delivery System Reform Incentive Payment (DSRIP) projects that depended on the foundation of the pilot and would expand that work. Ms. Brown informed the Committee that one of the requirements of the DSRIP waiver application was that funding requested through DSRIP could not be duplicated with any other sources of funding from CMS or the State. Accordingly, six of the 11 facilities would be funded by the CMMI grant and the remaining facilities would be funded through DSRIP.

Dr. Norris added that the active communication that resulted from the implementation of the ED Care Management program throughout the 11 facilities over the last couple of years would continue. Ms. Brown added that the learning collaborative introduced by Dr. Norris and the other senior sponsors of this program would also continue. Moreover, learning from the CMMI grant will also be shared with others. Ms. Brown explained that, like anything else, the goal is to ensure that one part of the corporation is working with the other and that all staff members are working towards the same end goal of transforming the delivery of health care services.

Ms. Brown informed the Committee that Dr. Sullivan, who is now the Acting Commissioner for New York State's Office of Mental Hygiene was very happy to learn of HHC's grant award notice.

Mr. Martin asked if acceptance by the ED physicians contributed to the success of the program as there had been barriers at the onset of the initiative. He also asked if the facilities that had been successful in achieving key performance targets had better cooperation from ED staff. Dr. Norris concurred that the acceptance of the overall staff, including the ED attending physicians, nurses and social workers, had been essential to the team and the program. She added that there were some enhanced successes depending on where the team was stationed and how embedded team members were within the geographic structure of the facility. Dr. Norris noted that, in some facilities, team members have to go around the corner and down the hall versus just being stationed side by side, elbow to elbow with the people they are working with. Therefore, this strategic structure makes those close conversations easier. In addition, because of ongoing training throughout the corporation, team members are more confident in the process. For that reason, training is also included in the new grant funded program to continue to teach team members some of the things that are essential to the success of the program. Dr. Norris reported that some ED staff were more into the traditional structure and had taken more time than other staff before gaining trust. Dr. Norris noted that even slower adapters have noticed how the program had added value to their departments over the course of the last year and a half. She stated that the team was very eager about the grant and the program enhancements.

Dr. Raju informed the Committee that, it is projected that by the year 2019, the federal government, as the major payer for Medicare and Medicaid insurance, would constitute 70% of the payer mix. Dr. Raju added that HHC had done very well internally with the pilot program and that the CMMI grant would give HHC some credibility externally and nationally as a transformative leader in healthcare delivery.

Mrs. Bolus thanked Dr. Norris and Mr. Divittis for their presentation.

## **ADJOURNMENT**

There being no further business, the meeting was adjourned at 11:20 AM.

**2014**

**New York State  
Legislative Session**



# 2014 Statistics

2

- ✓ 15,911 bills introduced
- ✓ 802 bills passed Senate only
- ✓ 458 bills passed Assembly only
- ✓ 658 bills passed both Houses
- ✓ HHC actively tracking 1083 bills





# Safe Patient Handling

3

## A.2180C (Gunther)/S.1123C (Maziarz)

- Requires hospitals, nursing homes and clinics to implement policies
- Requires process to allow staff to refuse to handle patients if they believe new policy is not followed



**Enacted as part of State Budget**

# Staffing Ratios

4

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

- 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
- **Did not pass EITHER house**



# Medical Malpractice

5

## A.1056A (Weinstein)/S.7130 (Libous)

- 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
- Amended to clearly apply to HHC and other public facilities
- **Did not Pass EITHER House**



# Job Order Contracts

6

## A.8757A (Abbate)/S.6618A (Savino)

- Would limit use of job order contracts
- Important procurement tool for HHC
- Allows for exceptions for work needed due to Hurricane Sandy or future State Disaster Emergencies
- **Passed Assembly Only**



# HHC Specific Legislation

7

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

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

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

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



# Hospital Legislation

8

- **A.746A (Rosenthal)/S.328A (Avella)**  
Information for Visually Impaired Patients
- **(A.9610B, Gottfried)/S.7234B, Kreuger)**  
Maternal Depression
- **(A.9611, Gottfried /S.7272, Hannon)**  
Quality Assurance for Trauma and Emergency Care
- **All bills Passed BOTH Houses**



# Professional Issues

9

- **A.7909 (Gunther)/S.6183 (Carlucci)**  
Mental Health Whistleblower Protections
- **A.9124A (Zebrowski)/S.6871 (Hannon)**  
Standing orders for Hepatitis C testing
- **A.9561A (Paulin)/S.7253 (Hannon)**  
Adult Immunizations
- **All bills Passed BOTH Houses**



# Health Insurance

10

- **A.9129A (Russell)/S.7852 (Young)**  
Coverage for Telehealth
- **A.8137A (Magnarelli)/S.5937A (Valesky)**  
Coverage for Ostomies
- **A.10164 (Cusick)/S.7912 (Seward)**  
Alcohol and Substance Abuse Parity
- **Passed BOTH Houses**





# Other Issues

11

- **A.6357E (Gottfried)/S.7923 (Savino)**  
Medical Marijuana
- **A.9768A (Gunther)/S.7481A (Hannon)**  
Surveys of Outpatient Mental Health Services
- **A.8162A (McDonald)/S.6449A (Hannon)**  
Prescription Refills
- **All bills passed BOTH Houses**



# Questions?

12

Wendy Saunders

Assistant Vice President for Intergovernmental Affairs

518-447-5200

[Wendy.Saunders@nychhc.org](mailto:Wendy.Saunders@nychhc.org)



## **RESOLUTION**

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to negotiate and execute a contract with Simpler North America, LLC ("Simpler") to provide "Lean" coaching, consultation and training services in support of the further implementation of Breakthrough throughout the Corporation, as well as for the acceleration of independence from outside expertise. This contract shall be for a total amount not to exceed \$10,494,000 for the period from November 1, 2014 through October 31, 2017, with two one-year options for renewal, solely exercisable by the Corporation, subject to additional funding approval by the Corporation's Board of Directors.

**WHEREAS**, a selection committee comprised of Corporation Central Office and HHC facility officials has considered applications received pursuant to a competitive bid process from six companies and has recommended that the Corporation enter into a contract for "Lean" coaching, consultation and training with Simpler; and

**WHEREAS**, the current contract with Simpler will expire on October 31, 2014; and

**WHEREAS**, the Breakthrough Improvement System has effectively and satisfactorily been implemented at nineteen Corporation sites, and the Corporation desires to strengthen its Breakthrough infrastructure to operate without outside assistance, align Breakthrough with strategic goals and fully implement the Daily Management System; and

**WHEREAS**, the Corporation has realized \$429.71 million in new revenue and \$35.36 million in cost savings through 1,600 Breakthrough improvement events, reaching 11,225 employees; and

**WHEREAS**, given the significant operational, clinical, financial and staff development benefits generated through Breakthrough activities with support from Simpler, and given the widespread support among leadership across the Corporation for a deeper and broader application of Breakthrough, the Corporation seeks to more fully imbed Breakthrough with expert guidance from Simpler; and

**WHEREAS**, the overall management of this contract will be under the direction of the Senior Vice President for Organizational Innovation and Effectiveness.

### **NOW THEREFORE, BE IT**

**RESOLVED**, that the President of the New York City Health and Hospitals Corporation be and hereby is authorized to negotiate and execute a contract with Simpler North America, LLC to provide "Lean" coaching, consultation and training services in support of the further implementation of Breakthrough throughout the Corporation, as well as for the acceleration of independence from outside expertise. This contract shall be for a total amount not to exceed \$10,494,000 for the period from November 1, 2014 through October 31, 2017, plus two one-year options for renewal, solely exercisable by the Corporation, subject to additional funding approval by the Corporation's Board of Directors.



## **EXECUTIVE SUMMARY**

### **Simpler, NA LLC Contract**

#### **PURPOSE**

For 6 years, pursuant to a competitive bidding process, HHC held a multi-year contract with Simpler, NA to provide lean consultation and training. At the termination of this contract, HHC issued a sole source contract with the firm for a 7<sup>th</sup> year. The application of lean in health care, while still novel in the industry has grown significantly over this period of time. In order to continue to have necessary external expertise available, while ensuring that the most appropriate and expert consultation was obtained, and further, in keeping with good contracting policy, HHC put the scope of work out to competitive bid in the Spring of 2014.

The division of Organizational Innovation and Effectiveness (OI&E) issued notice of the Lean Coaching, Consultation, and Training Request for Proposal to a list of vendors that have expertise in providing Lean-related services identified through discussion with colleagues in the field and our own experience, and posted the announcement of this issuance in the City Record. Forty-three (43) firms requested and received the Request for Proposal and six (6) firms submitted formal proposals. An internal Selection Committee comprised of seven (7) individuals was selected based on their high level of knowledge about and engagement in Breakthrough, and representing each HHC network and all levels of HHC senior leadership (SVP, ED, COO, CMO, clinical chief, Breakthrough Deployment Officer, OI&E). After OI&E determined that all submitted proposals were responsive, members of the selection committee independently reviewed all of the proposals and provided an initial ranking to each proposal based on pre-established criteria. The committee then chose the 3 top ranked proposing firms for oral presentations. This last step allowed for clarification of the written proposals and resulted in a final ranking. Simpler, NA ranked significantly higher than the other two firms who participated in oral presentations and was ranked number 1 of the 3 by each individual committee members as well as overall. Simpler, NA was selected for this scope of work as the firm that had the proposal best responding to the substantive and expense needs and requirements of HHC.

OI&E proposes that HHC enter into a three-year contract for the period of November 1, 2014 through October 31, 2017 with Simpler, NA for a total amount of \$10,494,000. The contract includes two optional, one-year periods which will be exercised and funded solely upon approval of the President of HHC according to current procurement policy.

Under this new contract, HHC will use Simpler's expertise, materials, approaches and development tools to continue, expand and improve HHC's transformation toward deeply embedding lean as HHC business system. Simpler has been engaged at all levels of the organization from the executive leadership for strategic planning (Hoshin Kanri), mentoring and development to conducting classes for all levels of staff and being 'sensei' for improvement events. During the new three-year period Simpler's role will evolve into advanced coaching, consulting and developmental support for leadership and managers as well as Breakthrough staff, supporting specific enterprise and site value streams and in assisting the implementation of model value streams. Concentration will be placed on building HHC's infrastructure to support improvement, promote alignment and develop current and future leaders. In the three years of this contract, HHC will not only continue on its journey to transform into a Lean problem solver

enterprise but will also develop a large cadre of leaders and managers who have the behaviors and skills to administer their areas of responsibility utilizing Lean methods. A new Leadership Institute will be instituted to accelerate the learning and development of HHC's current and future leadership. With the support and expertise from Simpler, HHC will accelerate its engagement and training of HHC leaders and staff in Breakthrough philosophy and tools as well as increase the efficiency, patient and staff satisfaction, strategic growth and financial well-being of all aspects of HHC.

## BACKGROUND

In November 2007, the New York City Health and Hospitals Corporation (HHC) executed a contract with Simpler Consulting, Incorporated (now Simpler North America, LP) for a three year period ending October 31, 2010. The contract for Lean training and consultation was procured through a competitive Request for Proposals process. From five qualified respondents, Simpler was selected based on experience, approach and cost. Three optional years were exercised as well as the current one year contract continuation of these services.

## CONTRACT HISTORY

<b>Process and Date</b>	<b>Period/Purpose</b>	<b>Amount</b>	<b>Cumulative Total</b>
Approval of original contract (November 2007)	Years 1-3 (11/1/07 - 10/31/10) with 2, 1-year optional renewal years	\$5,000,000 for Years 1-3	\$5,000,000
First Amendment (January 2010)	Increase budget authority for the original period (Years 1 – 3) to add depth and breadth to contractor scope*	Add \$2,000,000 to Years 1-3	\$7,000,000
Renewal and Second Amendment (October 2010)	Execute the first of 2 optional renewal years (Year 4: 11/1/10-10/31/11) and add a third optional renewal year to ensure development of all sites and build self-sustaining infrastructure	Add \$3,112,700 for Year 4	\$10,112,700
2 <sup>nd</sup> Renewal and Third Amendment	Executed 2 <sup>nd</sup> of 3 optional renewal years (Year 5: 11/1/11-10/31/12)	Add \$4,879,650 for Year 5	\$14,992,350
3 <sup>rd</sup> Renewal and Fourth Amendment	Executed 3 <sup>rd</sup> of 3 optional renewal years (Year 6: 11/1/12-10/31/13)	Add \$5,500,000 for Year 6	\$20,492,350
New Simpler Contract	Executed new contract with Simpler for one year period: 11/1/13-10/31/14	New amount of \$4,416,000	\$24,908,850

In March, 2014 approval was obtained from the Contracts Review Committee to submit a Request for Proposal for Lean Coaching, Consultation and Training services. A total of 43 companies received the RFP and 6 submitted formal proposals. A selection committee comprised of administrative and clinical leaders from across HHC facilities reviewed all proposals, held in-person interviews with the selected top proposers and through a formal written evaluation process selected Simpler, NA as the top proposal.

The total amount of the contract for the three-year period November 1, 2014 through October 31, 2017 is \$10,494,000.

## **OUTCOMES TO DATE**

In the almost seven years that HHC has implemented Breakthrough with Simplr's support, HHC has realized \$429.71 million in new revenues and \$35.4 in cost savings on a contract budgeted expense of \$24,908,850. In addition, over 11,225 staff has been engaged in Breakthrough events and over 1,600 Rapid Improvement Events have been completed. Breakthrough has now been implemented at 19 of HHC's 23 major sites and sub-organizations<sup>1</sup> resulting in improvements in areas such as peri-operative services, emergency departments, inpatient units, ambulatory care, revenue cycle, imaging and behavioral health. Not only has this effort resulted in increased revenue and cost savings but it has also improved safety, efficiency and capacity, and decreased patient waits, unnecessary staff and patient movement and unneeded steps in numerous processes. ROI continues to grow at an increased rate: the cumulative ROI over these 7 years is \$18.67 financial contribution for each \$1 spent on the contract.

## **CONTRACT SCOPE**

During the proposed three-year period, Simplr will focus on the strategic areas below that have been identified as critical to Breakthrough's and HHC's success:

### **1. Visioning and Strategy**

The Vision and Strategy services provide coaching to executives and helps tighten the strategic alignment between HHC's business goals and Breakthrough's efforts to ensure the highest client benefits and return-on-investment, while balancing the efforts of performance improvement and culture change. Included in this service are: More in-depth Hoshin Kanri (strategic) planning and TPOC (transformational plan of care) reviews and guidance.

### **2. Architecture and Infrastructure (A&I) – 'Building Capability'**

The goal of the A&I services is to convert the Simplr Business System® (SBS) to an "HHC Business System". This will become the business system that HHC will own and use going forward in HHC's Lean journey. Included in this initiative are three new initiatives:

- a. Leadership Institute Service
- b. 'Self-sufficiency' Coaching and Writing Cell Service
- c. Human Development Value Stream Service

### **3. Value Stream Improvement – 'Creating Flow'**

Unlike previous HHC contracts, network/site support in the 2015-2017 contract will be specifically assigned and supported either by a Simplr Sensei or by the HHC Corporate Breakthrough Office. Simplr will assign Sensei to 5 of the 6 HHC Networks to support specific sites and 'model value stream' work to help create 'What Good Looks Like' for HHC. This approach is intended to accelerate the pace of HHC learning; drive HHC internal capability building and self-sufficiency; enable a holistic approach to system development and; improve the True North performance of the value streams targeted for Sensei support.

### **4. Managing for Daily Improvement (MDI) – 'Developing Discipline'**

MDI, *branded as Daily Management System (DMS)* at HHC, is focused on implementing a management system that creates, accommodates, and sustains a culture of continuous

improvement. Participants will gain an understanding of the fundamentals of the MDI System which is used as part of your transformation to a data driven, action oriented, engaged, and empowered Lean organization. Simpler will provide Sensei and Gemba Coaches to help implement and sustain your long-term goal of implementing DMS in ~244 areas at HHC.

### **5. Enterprise Opportunity Identification**

Simpler will provide resources to identify enterprise-wide performance and financial opportunities to inform your strategy, Hoshin Kanri deployment, and direct your improvement or innovation activities. Simpler will conduct a ‘diagnostics’, typically over a 4-8 week period, to identify both cost and revenue opportunities. As a result of the diagnostics, HHC will have a list of areas with quantifiable financial or performance gaps. Simpler intends to combine the power of Truven analytics, such as ‘100 Top’, Action OI, and their information on population health, with the diagnostics to provide meaningful financial and performance

### **6. Lean Innovation Service**

In the changing healthcare landscape, each healthcare system has two priorities:

- *Conversion* - Continue to improve the current processes as it relates to quality, safety, access, cost and patient satisfaction
- *Innovation* - Develop innovative methods that ensure vitality for the future

Simpler uses the *Simpler Business System*® to help organizations convert the current clinical and non-clinical processes. Simpler uses the *Simpler Design System*<sup>SM</sup> (SDS) to help companies innovate. We help organizations innovate in 5 key areas:

Develop an Innovation Center

- Develop a New Value Proposition (e.g. Develop a population health business model)
- Develop a New Care Pathway across the enterprise (e.g. Chronic Disease, Children or Healthy Adult)
- Develop a New Service Line (e.g. Oncology)
- Develop a New Technology

It is important that a percentage of all continuous improvement efforts be focused on innovation and now that we have embedded the core principles across significant parts of HHC, we are better positioned to drive Innovation than ever before.

A notational schedule depicting Simpler’s resource deployment over the three year period is attached.

### **CONTRACT BENEFIT TO HHC:**

November 1, 2014 through October 31, 2017:

- New Revenue: \$ 205 million      Cost Savings: \$10 million

Other anticipated outcomes of Breakthrough efforts include:

- Number of Rapid Improvement Events: 720
- Number of additional employees participating in Breakthrough activities: 8,000
- Rapidly expanded number of sites will be trained in the Daily Management System and thereby being able to continuously improve and sustain these improvements.
- Leadership will be placed on an accelerated pace to become more skilled and knowledgeable about the application of tools to plan, implement and sustain Breakthrough activities.

Managers will be able to improve their own and their areas of responsibility’s productivity through the use of Breakthrough tools and philosophies on a daily basis



- HHC will become more self-sufficient to implement Breakthrough improvements with a leadership, management, staff and systems which are empowered and support improvement.
- Sites will have increased capability to manage projects, increase the effectiveness of their Breakthrough events and the ability to use more advanced tools to achieve greater success. Employees will be empowered to problem solve and improve the processes in their own areas.
- Patient and employee satisfaction will be increased due to the elimination of wasteful, unneeded processes, wait times and unnecessary movements.

## **CONTRACT MANAGEMENT**

The contract will continue to be monitored by Joanna Omi, Senior Vice President, the Division of Organizational Innovation and Effectiveness.

<sup>1</sup> Breakthrough had been adopted at Central Office, Queens Hospital Center, Metropolitan Hospital Center, Jacobi Medical Center, Gouverneur Healthcare Services (D&TC and SNF), Renaissance, S.R. Belvis, Morrisania and Cumberland Diagnostic and Treatment Centers, Coney Island Hospital, Bellevue Hospital Center, North Central Bronx Hospital, Woodhull Medical and Mental Health Center, Kings County Hospital Center, Lincoln Medical and Mental Health Center, Elmhurst Hospital Center, Harlem Hospital Center, Coler/Carter Specialty Hospital, and Health and Home Care.



**Health and Hospitals Corporation  
Contract Review Committee  
Contract Approval Form**

Date: 30 June 2014

To: Lawrence Hansley

Document Control Number: 2171

**Description:** Application seeking authorization to enter into a contract for Lean Coaching Consultation and Training Services with Simpler, North America, LLC on behalf of the New York City Health and Hospitals Corporation, Division of Organizational Innovation and Effectiveness.

The Contract Review Committee (CRC) reviewed the referenced submission during its June 18, 2014 meeting.

- The financial amounts on the Executive Summary, Resolution, and Contract Fact Sheet are to be corrected to show consistency.
- Contract payment terms are to be reviewed by Jay Weinman.
- Define "Return on Investment" calculation as savings attained by the Corporation through the work and efforts of the Corporation's Administration and Line staff using the principal of Lean and the Breakthrough events conducted by Simpler

  
\_\_\_\_\_  
**Joseph Quinones, SAVP  
Contracts Administration & Control**

**The Contract Liaison must confirm incorporation of changes; resubmission is not required. A copy of the revised documents must be submitted to the CRC Chairperson.**



**Manasses C. Williams**  
Assistant Vice President  
Affirmative Action/EEO

manasses.williams@nychhc.org

**TO:** Larry Hansley  
Director  
Central Office - Office of Corporate Planning & HIV Services

**FROM:** Manasses C. Williams

**DATE:** June 12, 2014

**SUBJECT:** EEO CONTRACT COMPLIANCE

---

The proposed contractor/consultant, Simpler North America, LLC, has submitted to the Affirmative Action Office a completed Contract Compliance Questionnaire and the appropriate EEO documents.

This company is a:

Minority Business Enterprise  Woman Business Enterprise  Non-M/WBE

Project Location(s): HHC Corporate-Wide.

Contract Number: \_\_\_\_\_

Project: Provide Lean Consulting Services

Submitted by: Office of Corporate Planning & HIV Services

EEO STATUS:

1.  Approved
2.  Conditionally approved with follow-up review and monitoring-No EEO Committee Review
3.  Not approved
4.  Conditionally approved subject to EEO Committee Review

COMMENTS:

c:





# Coaching, Consultation and Training

Contract with Simpler, North America LLC

Presentation to the Strategic Planning Committee

July 8, 2014

# Agenda

- Background
- Achievements
- Proposed Contract

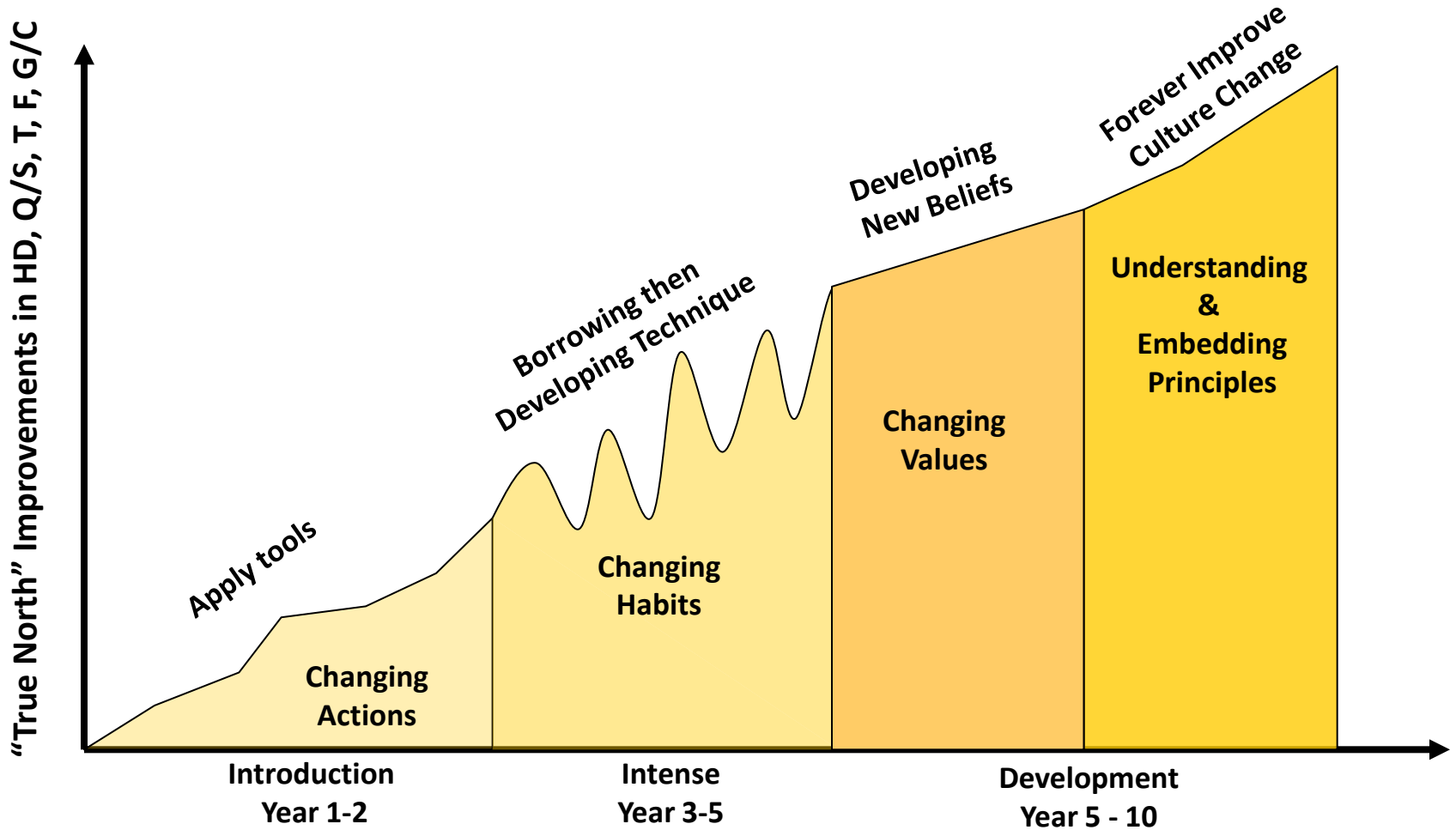




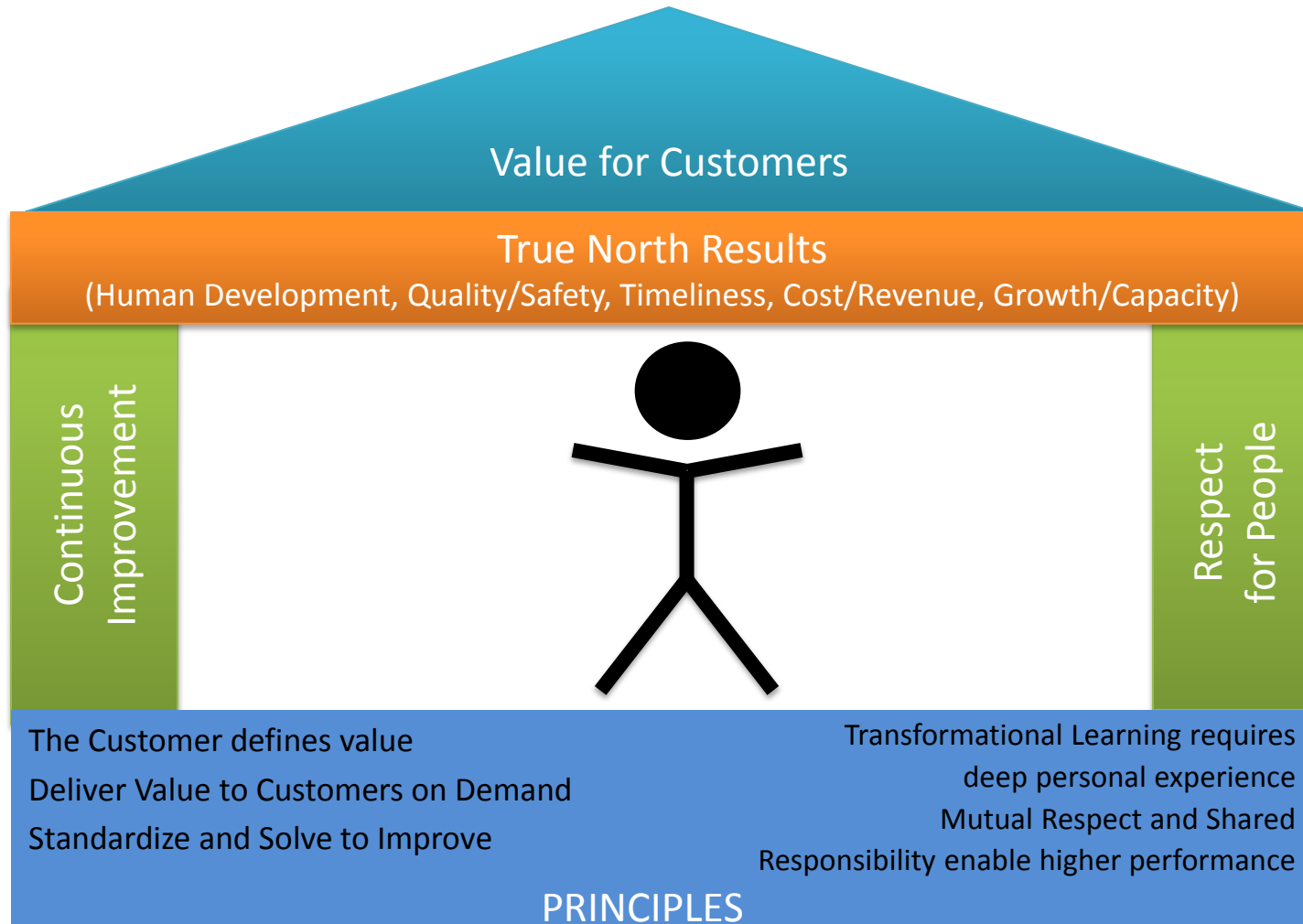
# Breakthrough is...

A ***principled operating system*** with powerful tools for improvement and change founded in a philosophy of ***continuous improvement*** and **respect for people**. We strive to effectively provide ***high quality services to customers without waste***. Breakthrough is transforming the way we conduct business at HHC; we are becoming a community of ***empowered problem solvers*** that embraces innovation in the pursuit of ***zero defects***.

# Transformation Journey



# Pillars and Principles



“Management commits to continuously invest in its people and promote a culture of continuous improvement.” [The Toyota Way, Liker, J. 2004.]

# Approach and Essential Tools

- Identify demand
- Calculate takt time
- Solve for takt time
- Create flow
- Eliminate
  - Waste
  - Overburden
  - Unevenness
  - Improve flow to deliver value on demand
- Standardize
- Manage visually

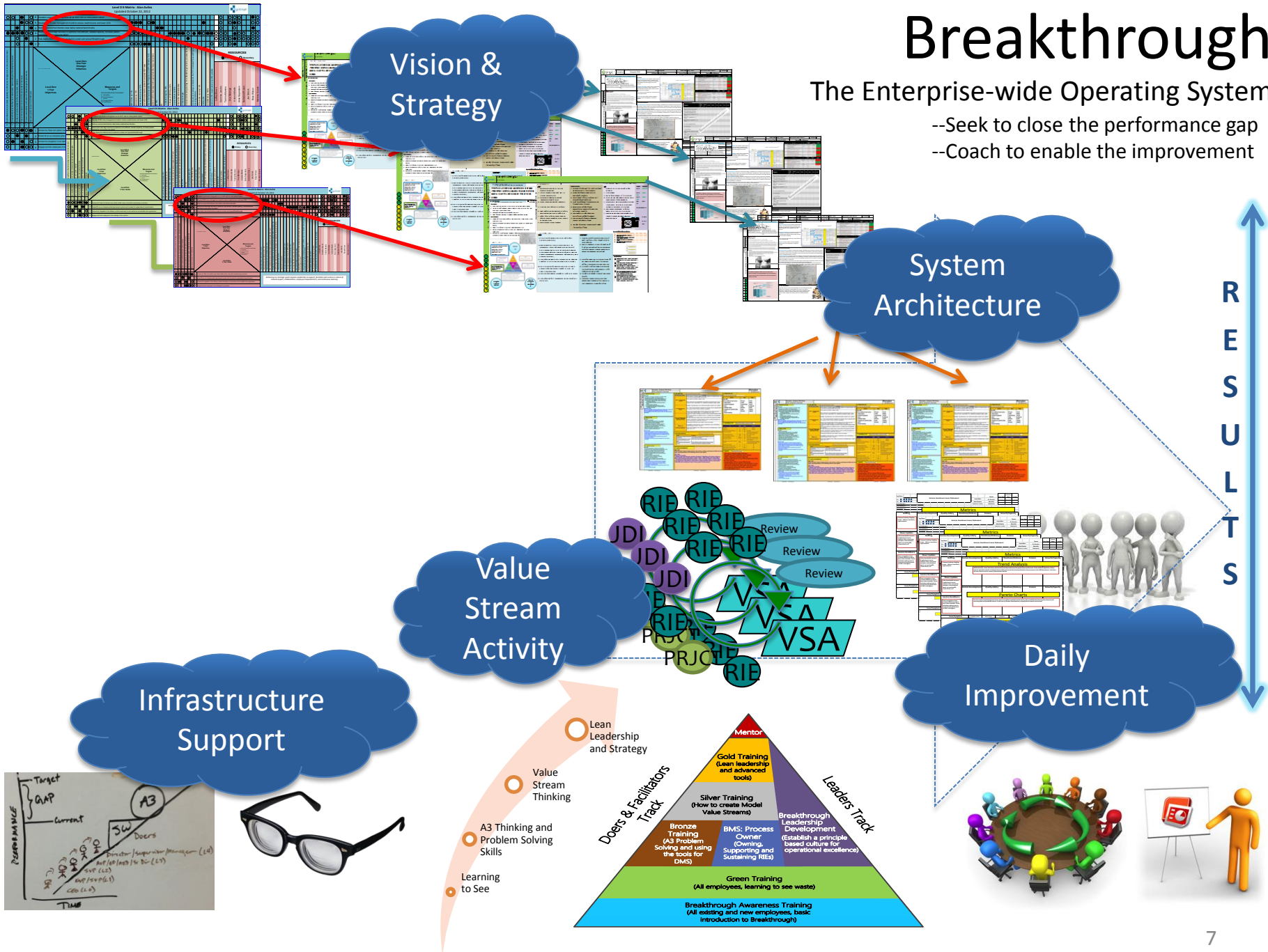


- A3 Thinking
- Visioning Workshops
- Value Stream Analysis
- Vertical Value Stream Mapping
- Rapid Improvement Events
- Daily Management System
- Process Preparation (2P)

# Breakthrough

The Enterprise-wide Operating System

- Seek to close the performance gap
- Coach to enable the improvement



# Typical 8 Wastes in Healthcare

## D Defect

*(Errors , near misses, inspection)*



## O Overproducing

*(Too much & too early)*



## W Waiting

*(Queuing, idle time)*



## N Not Using Skills

*(Not using problem solving of people)*



## T Transportation

*(All patient, staff and material movement)*



## I Inventory

*(All stock & corresponding control systems)*



## M Motion

*(Reaching, bending, searching ....)*



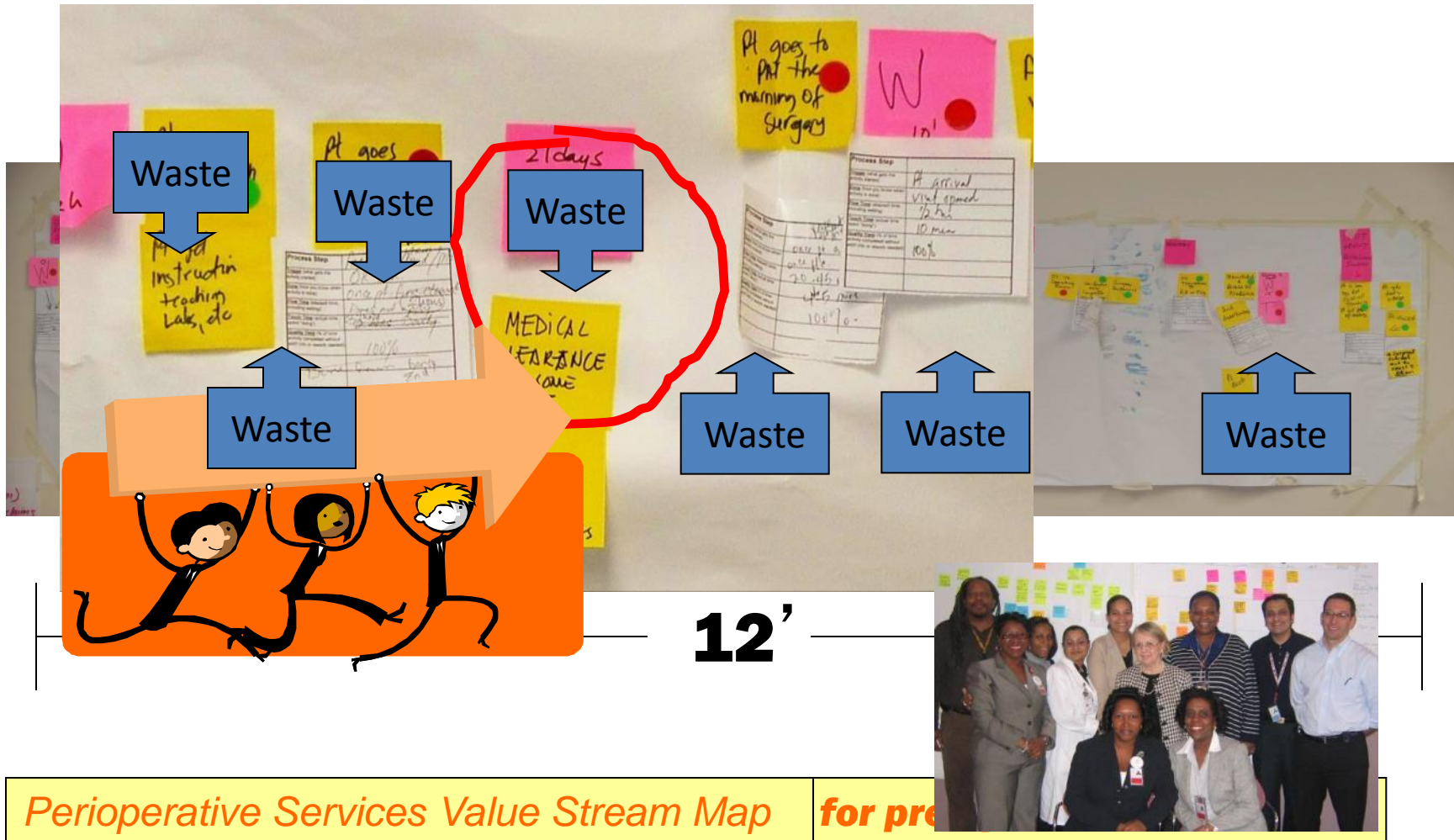
## E Extra Processing

*(Unnecessary activities, overly complicated processes)*

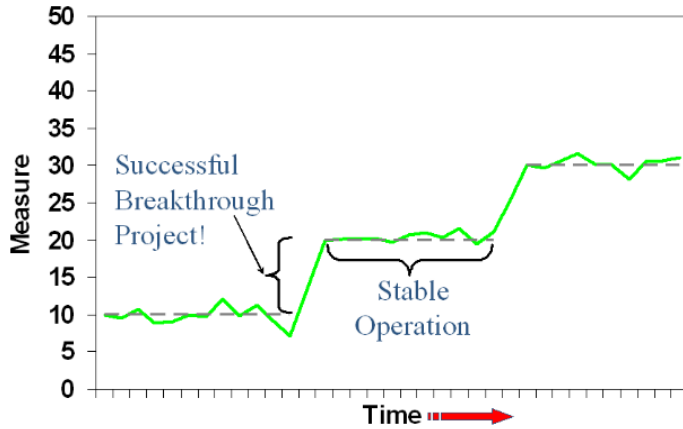


# Value Stream Mapping

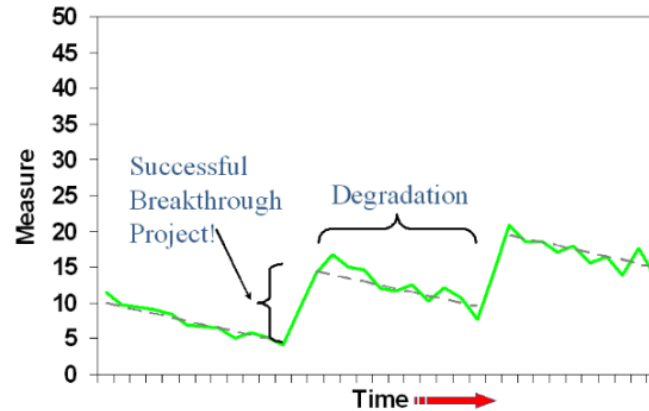
- Select and Map Value Streams
- Eliminate Waste and Improve



We expect BREAKTHROUGH improvement with RIES



But in fact, absent a management system, degradation of the improvement occurs



Combined, we achieve continuous incremental improvement punctuated with stair-step breakthroughs



# Synergistic RIEs and DMS



# Daily Management System

A system for identifying work site goals and managing performance to these goals...

... through the engagement of staff and managers in the

... collection and review, in real-time, of data, as well as the application of

...problem solving tactics to remove obstacles and continuously improve performance

DMS is about People.



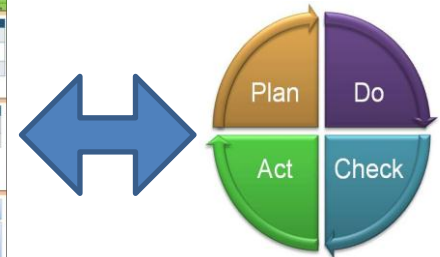
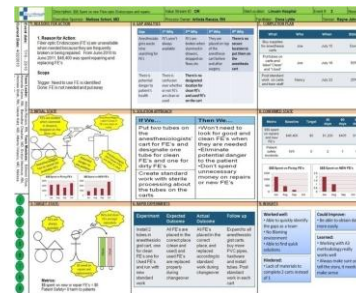
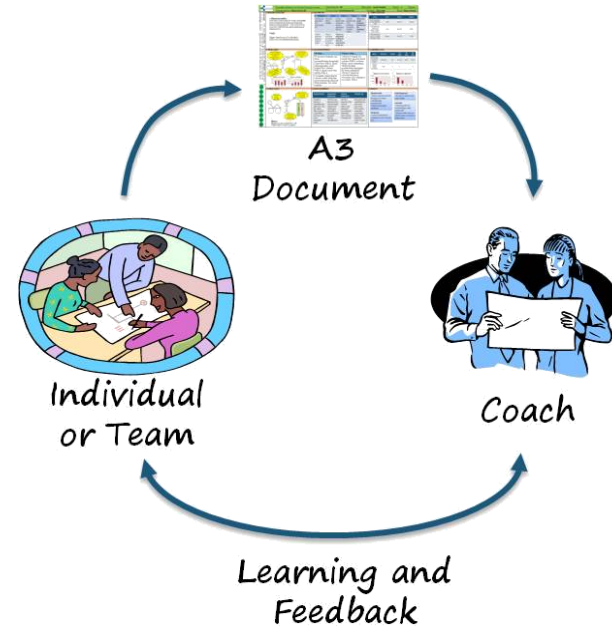
*DMS at Woodhull*



*DMS at Metropolitan*

# A3 Thinking

- A3 an 11" x 17" sheet of paper ...but what else?
- It is a foundational **management process** that enables and encourages learning through the **scientific method**
- It is a problem-solving structure involving **visual manifestation** and **continual dialogue** between the owner of the problem and others
- It forces individuals to **observe reality**, present facts, propose working **countermeasures** designed to achieve the stated goal, and **follow up** with a process of checking and adjusting for actual results (PDCA)



# Breakthrough Training Conceptual Framework

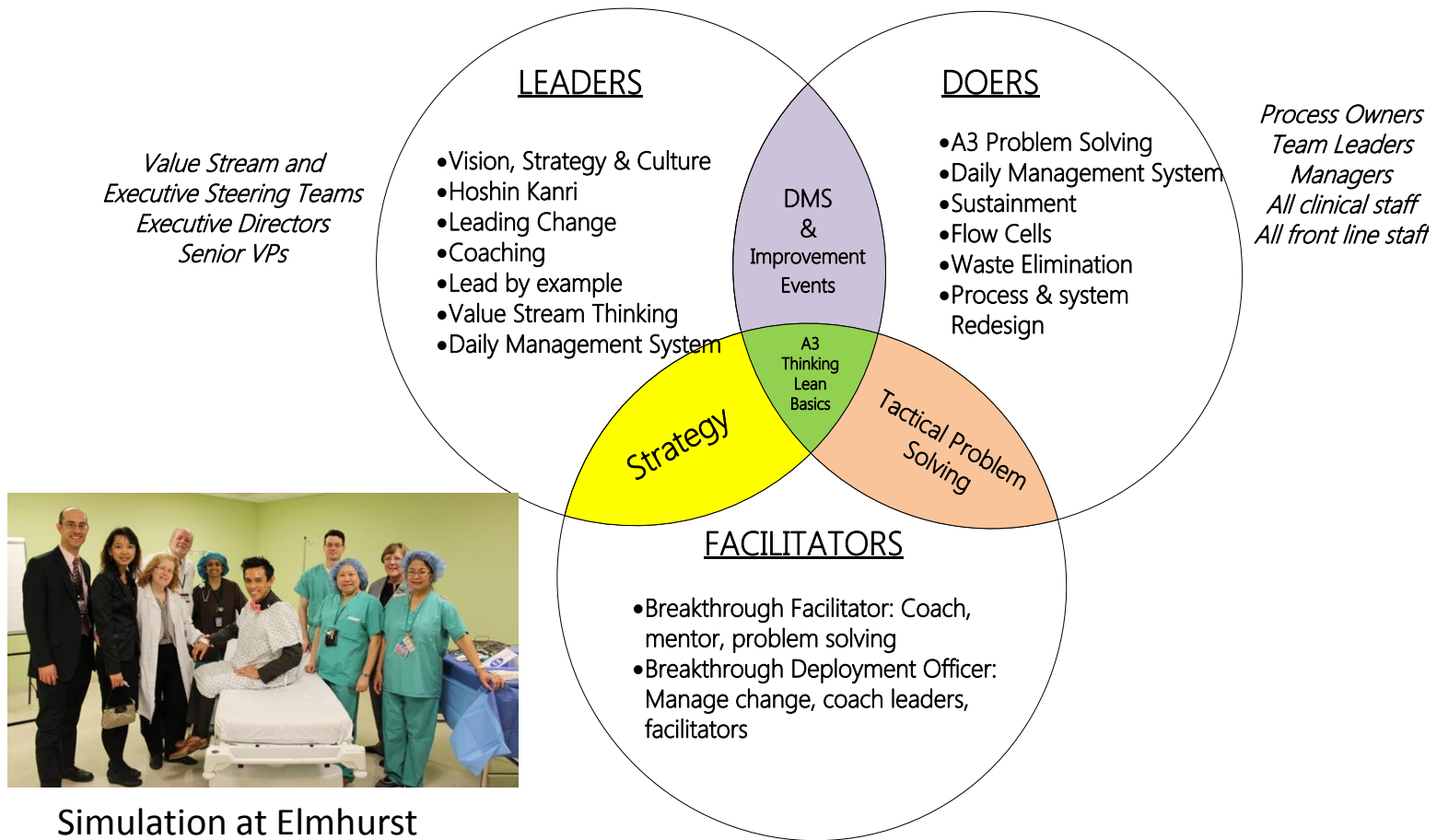
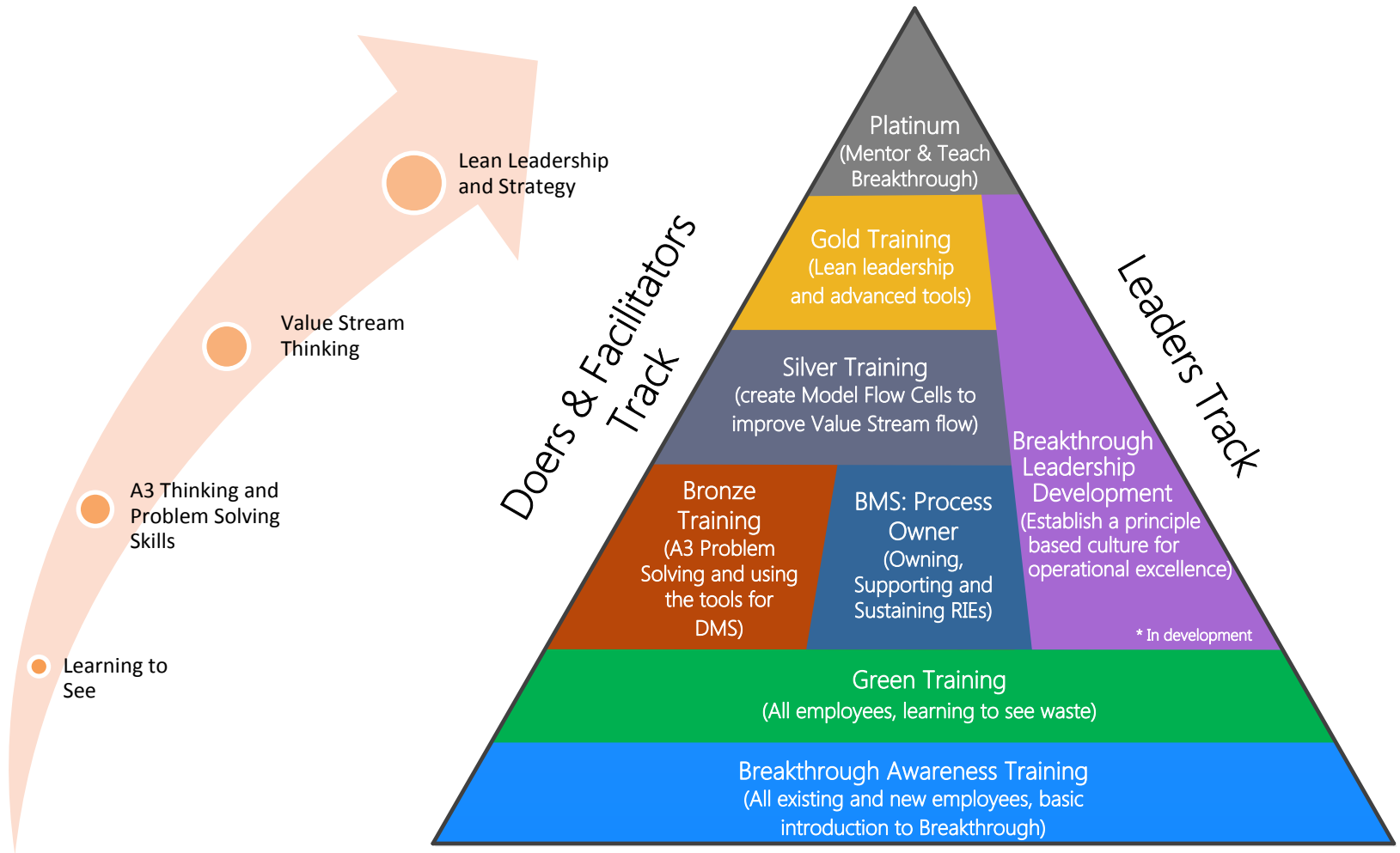
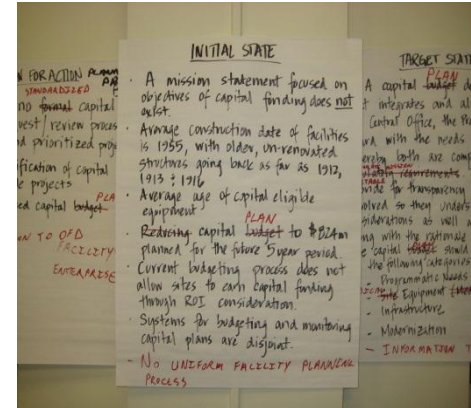
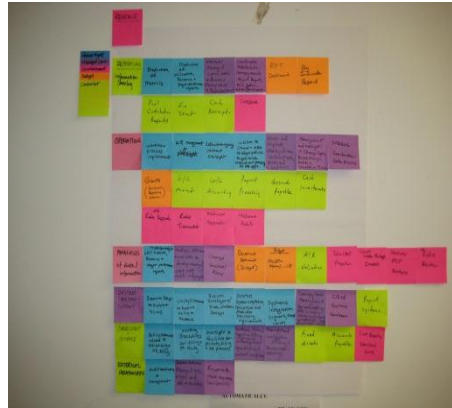


Fig. 1 Breakthrough Training Conceptual Framework

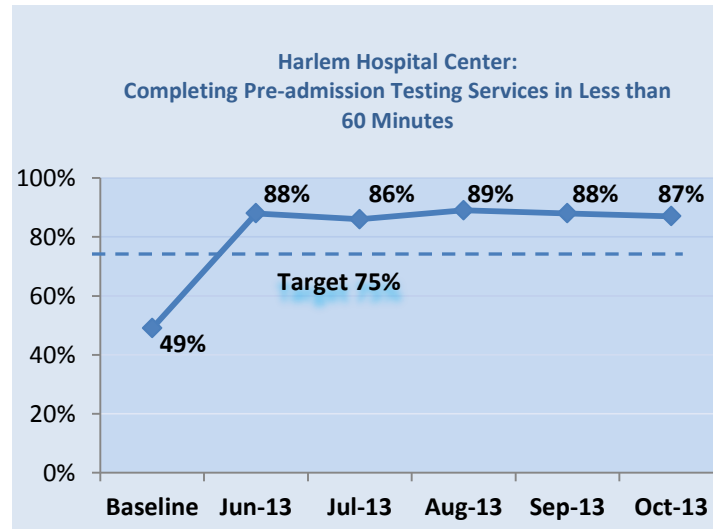
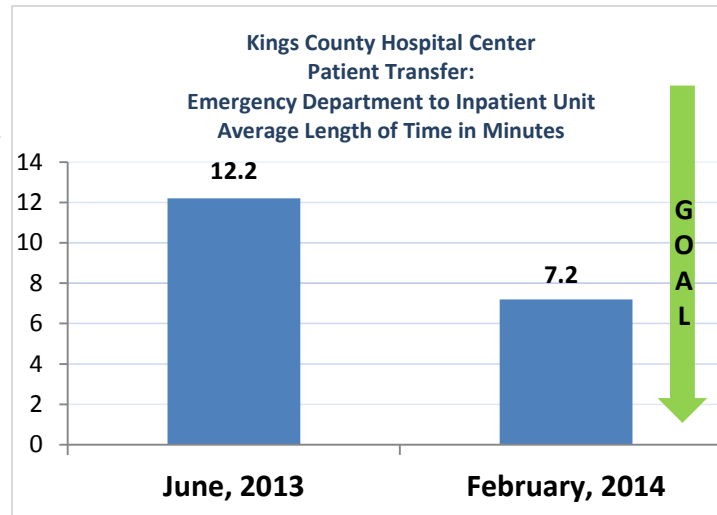
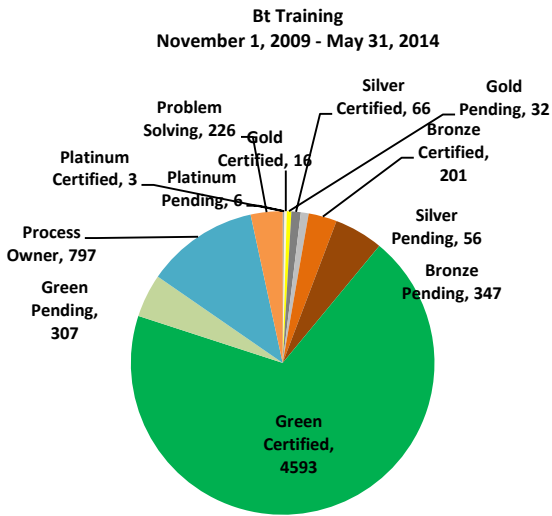
# Breakthrough Training Program



# Achievements

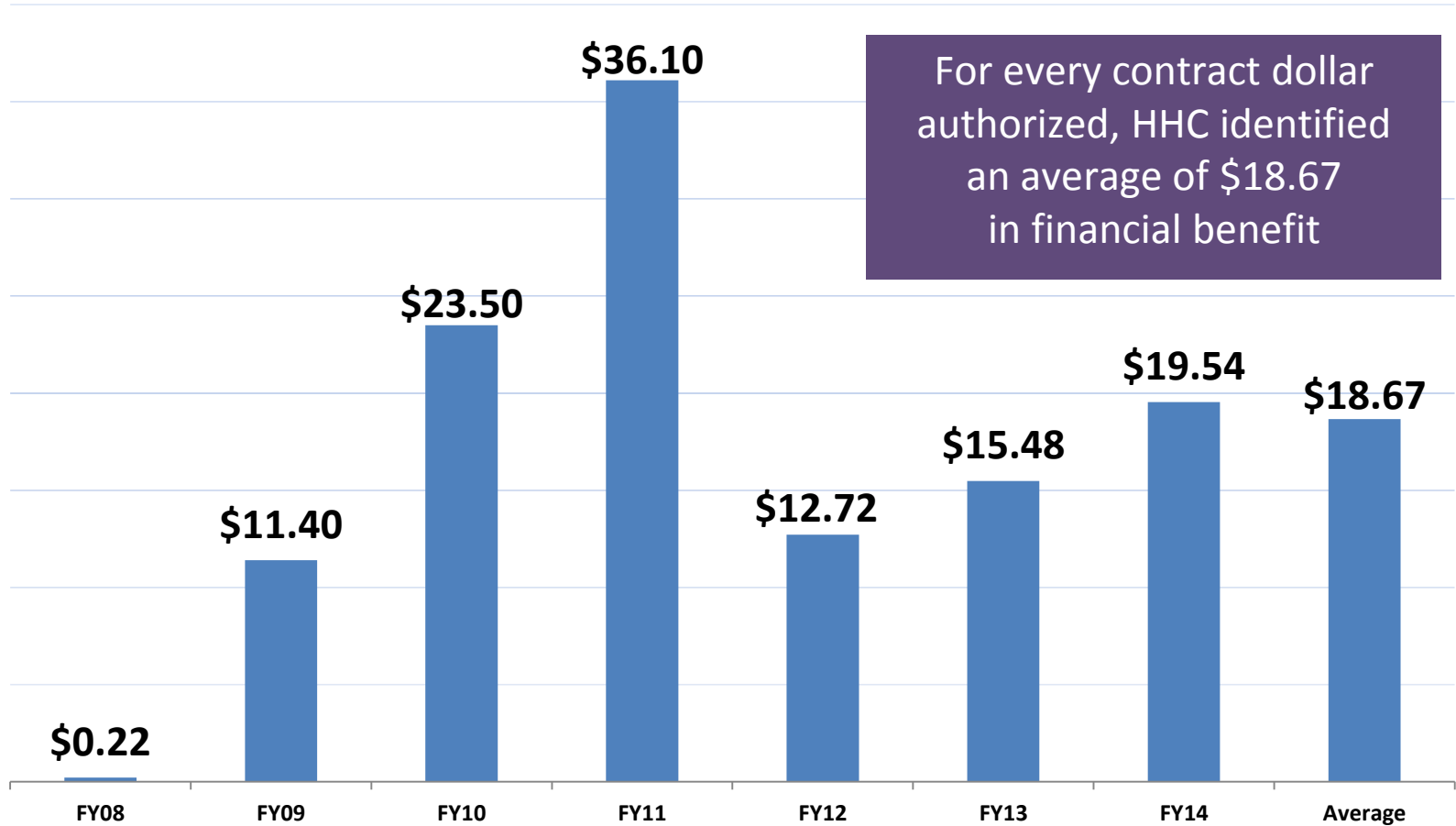


# Improvement Across the System



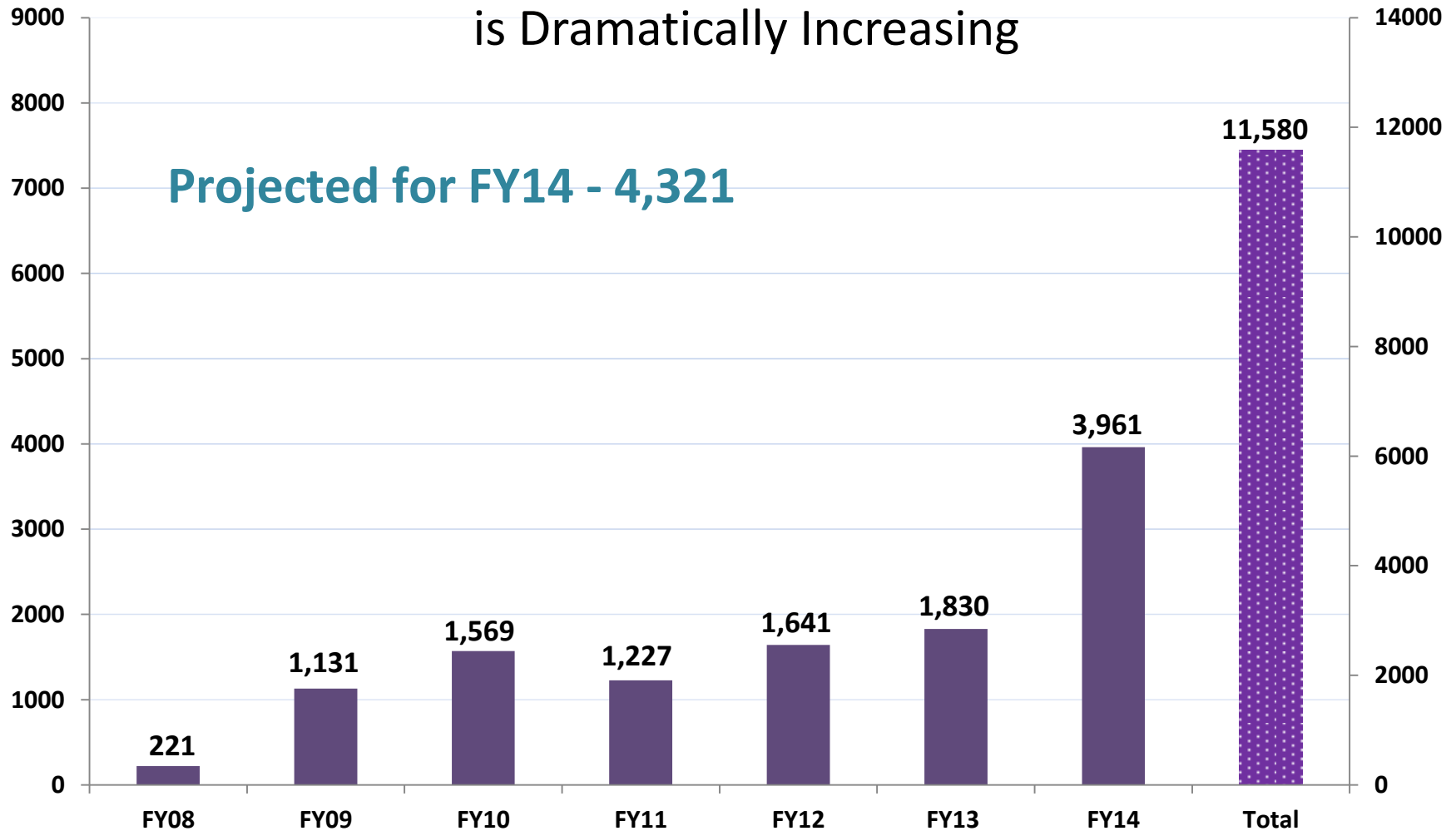
# Strong Return on Investment

Annual Financial Benefit per Authorized Contract Spend by Fiscal Year  
(based upon \$465M cumulative actual financial benefit)



# Employee Engagement

New Employee Participation in Training and Events  
is Dramatically Increasing

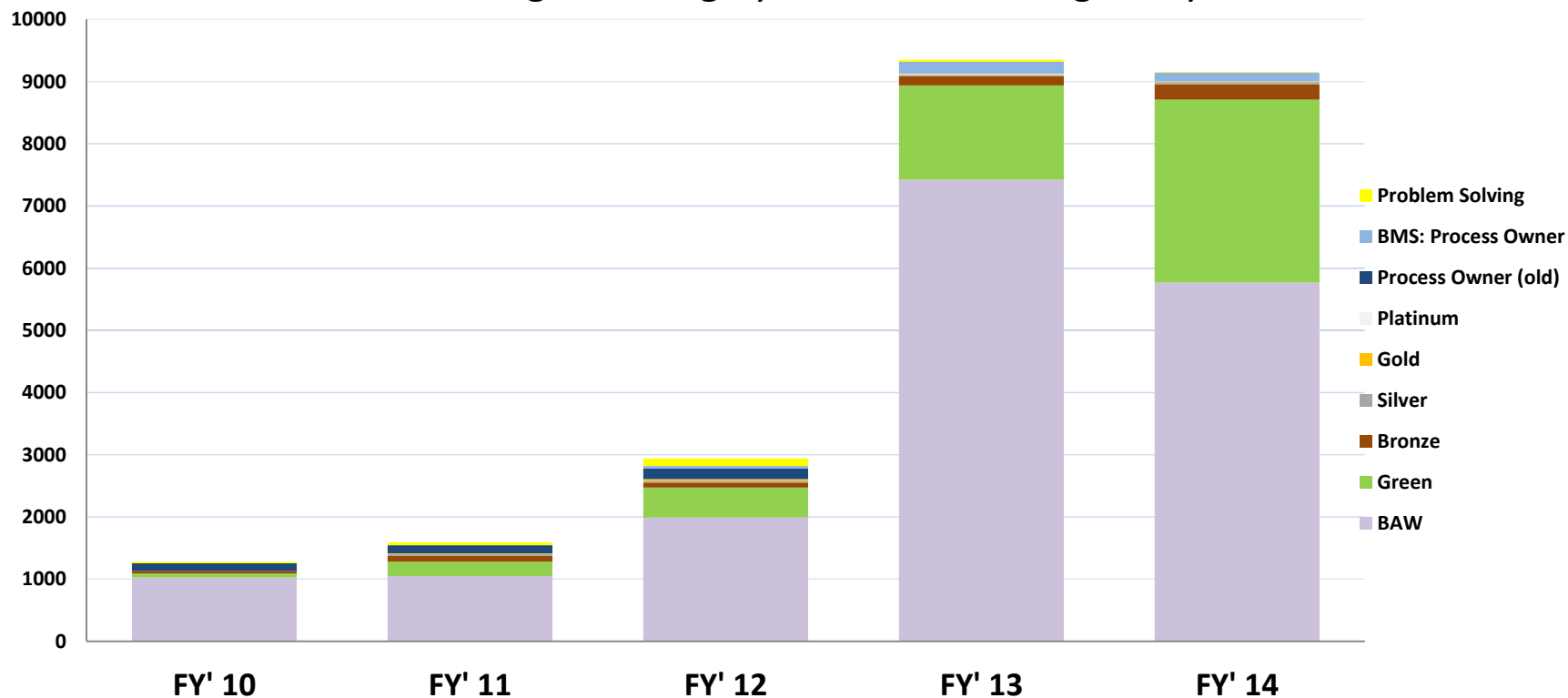




# HHC Breakthrough Training Program

HHC Assumed Complete Responsibility for the Breakthrough Training Program in FY 14

Breakthrough Training by Fiscal Year through May, 2014



# Harlem Hospital Center

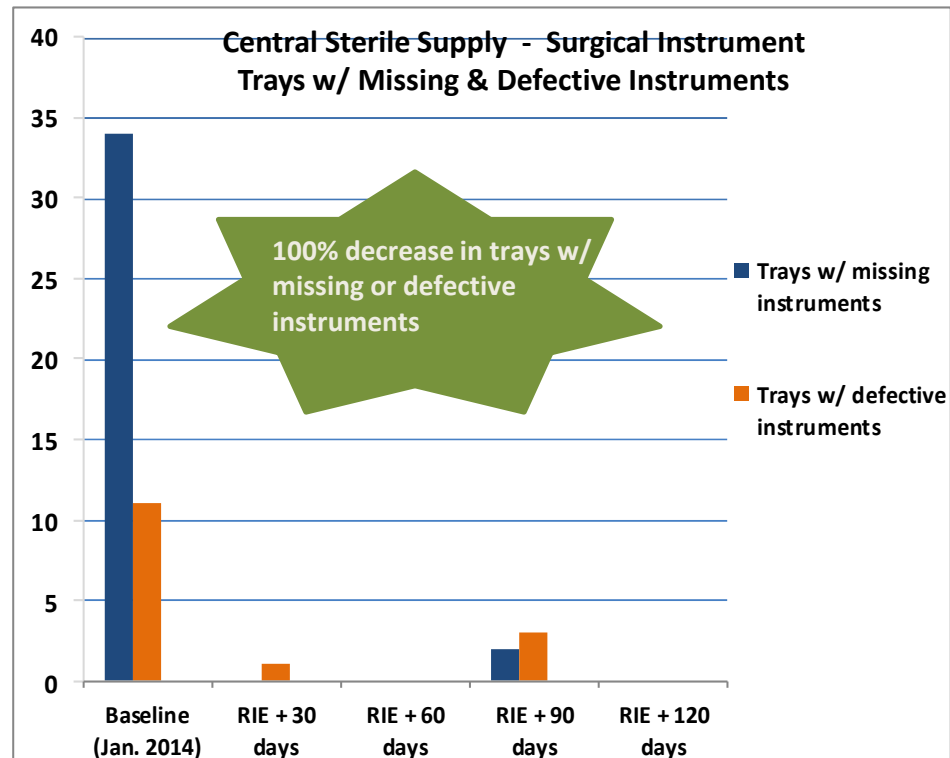
## Perioperative Service

### Problem statement:

Analysis of flow in Operating Rooms identified surgical instrument trays with missing and/or defective instruments as a major source of delays. These delays are both in providing patients with timely services as well as poor use of the O.R.s, providers and staff time.

### Improvements:

- Created standard work for the identification of missing and defective instruments
- New standard work developed for revising case counts in Abacus system
- Implemented process control board to visually manage the preparation and delivery of surgical trays
- Created communication loop between OR (point of use) and Central Sterile Supply



Trays with missing instruments	34	0	0	2	0
Trays w/ defect instruments	11	1	0	3	0

**Targets = 0**

# Kings County Hospital Center

## Inpatient Adult Medicine Value Stream

### Patient Escort Services

#### Problem Statement:

Frequent delays in transportation create dissatisfaction among staff and patients; and can lead to delays in discharges. Demand and capacity of transport services needs to be assessed in order to optimize our transport services and ensure resources are allocated to meet demands.

#### Improvements



Improved communication among escorts and dispatcher

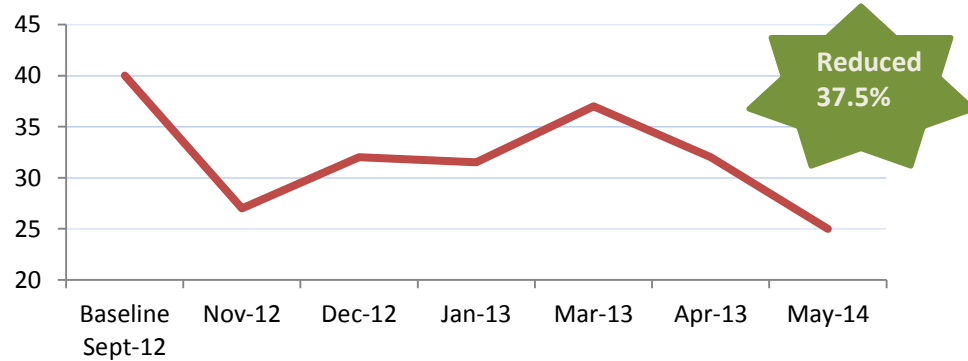


Procedure schedules communicated to Units

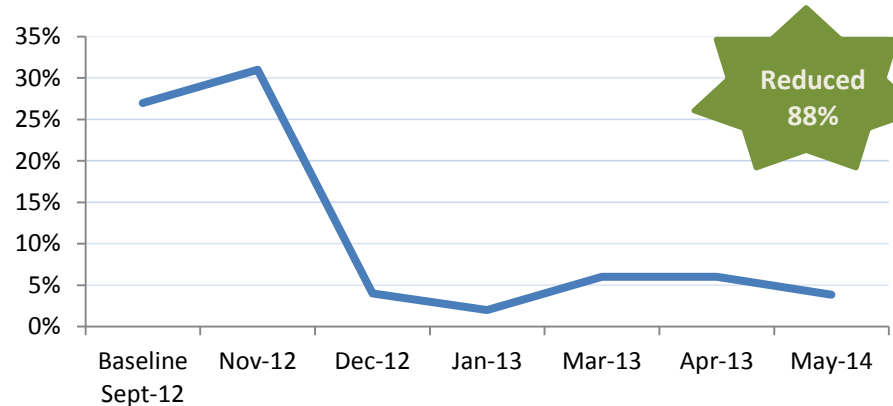


Balanced workload among escorts. Accountability built-in

Cycle time from request to patient transport



Patients not ready to be transported



# Bellevue Hospital Center

## Patient Waits for Pharmacy Services

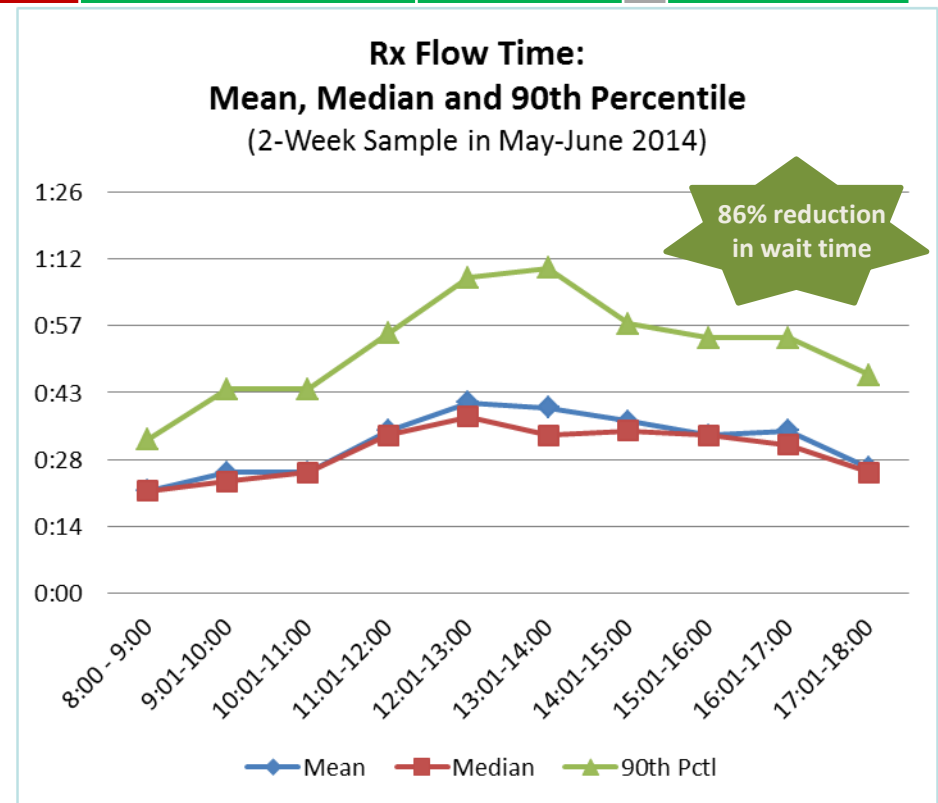
Metric	Baseline	Target	Jan' 14	Feb '14	June '14
Flow time	4 hours	1 hour	39 Min	33 Min	34 Min

### Problem Statement:

Current Pharmacy process result in extensive wait. We don't manage patients expectations well; We don't communicate effectively with our patients. These processes in turn cause stress to our staff. In addition, we must relocate the drop off area, which may improve our overall process. If we do not improve Patient Experience and reduce wait times we will not be able to compete in the near future.

### Improvements:

- Created two flow cells
- 6S conducted to improve flow
- New standard work for labeling/bagging
- Patient alert system installed
- Reduced time from 4 hours to 34 minutes



This graph allows us to predict patient wait by time of the day. Data will be validated on the ongoing basis.

# Lincoln Hospital

## Decreasing Patient Median Wait Time In Medicine Clinic

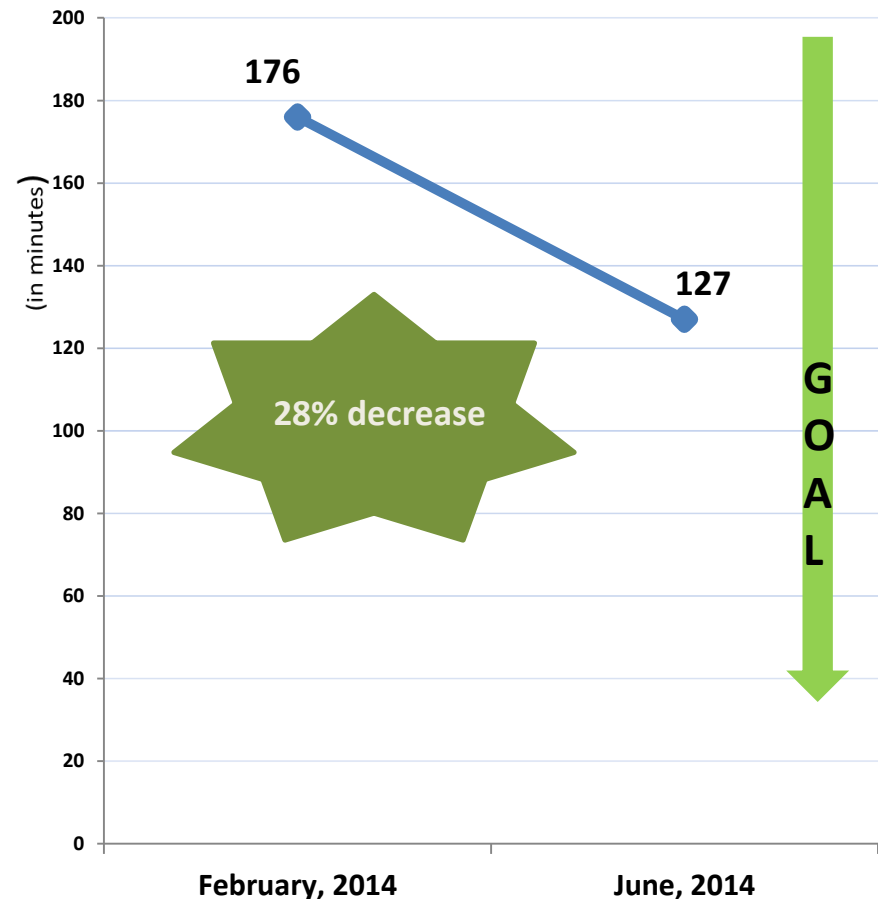
### Problem Statement:

Patients dissatisfied with long waits for services in the Adult Medicine Clinic

### Improvements:

- New standard work for patient flow
- Utilize process control board to improve clinic operation
- Conduct daily briefs to improve provider/staff communication and preparation for clinic
- Conducted A4 Problem Solving and Time Observation studies to identify and remove inefficiencies in patient flow

Patient Median Wait Time In Medicine Clinic



# Metropolitan Hospital Center

## Reduction of Inpatient Detox Denials

Metric	Baseline	Target	Jan' 14	Feb '14	March '14
Detox Documentation of Medical Necessity	0%	50%	81%	88%	94%
CIWA and CINA Evaluation in ED	0%	50%	97%	97%	99%
Detox Denials	\$847,000 (30)	\$347,000	0	0	\$5,954 (2)

### Problem Statement:

The Metropolitan Psychiatric ED admits patients for inpatient detoxification that can be directed to another level of care. As a result, we receive a large volume of denials. In FY 13 there was an average of 30 denials per month at a cost of \$847,000 to the facility (\$70,583/month).

### Improvements:

- ✓ ED staff trained on HHC redirection policy
- ✓ ED nurses trained on the use of CINA/CIWA
- ✓ ED residents trained on the use of the ASAM document template criteria for admission
- ✓ Track amount of patients admitted to Detox with medical necessity documented
- ✓ Track patients admitted to Detox have CIWA/CINA completed and in the chart
- ✓ Develop a list of OPD detox recourses and accepted insurance
- ✓ Develop a spread sheet for residents to track detox admission with appropriate doc and CIWA/CINA assessment
- ✓ Implementation of updated HHC pre-admission screening form

Documentation increased by 94%

Denied payments decreased by 97.2%

# Jacobi Medical Center

## Peri-operative Services Model Value Stream

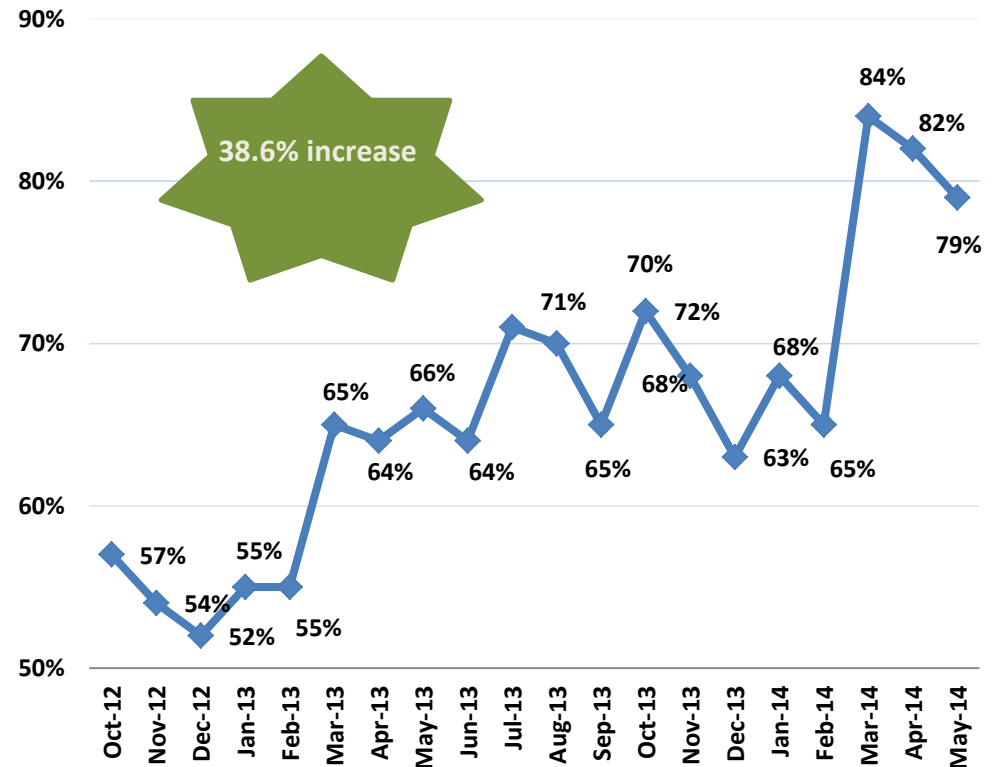
### Problem Statement:

Delays in the start of the first cases in the Operating Rooms causes patient waiting and inefficient utilization of room, instrument, physician, nursing and staff times

### Improvements:

- Process Control Board
- Pre-Op checklist implemented
- Holding area bay readiness
- 2P to improve patient flow for PAT

### 1st Case On-Time Start



# Daily Management System

## Achievements

*6 Sites' Results—2013- 2014*

- Patients seen by their Primary Care Provider in the Adult Practice increased from 75% to 95%-Kings County
- Patients leaving within 15 minutes of being identified for discharge increased from 86% to 93%-Bellevue
- Urgent Care patients seen by provider within 30 minutes increased from 30% to 52%-Metropolitan
- Patient cycle time in Adult Medicine Clinic reduced an average of 25 min-Lincoln
- Percent of self-pay patients who were in contact with a Financial Counselor increased by 260% -from 27% to 97%-Queens
- Percent of patients seen within one business day of admission increased 58% - from 36% to 57%-Elmhurst





# Contract History

- Breakthrough initiated November 2007
- Simpler procured via competitive RFP
  - **SCOPE:** Lean consultation and support services
  - **TERM:** 3 years (2007—2010 with 2 one-year optional renewals)
  - **ORIGINAL BUDGET:** \$5M
  - **FIRST AMENDMENT:** Increase total to \$7m; no change in term (January 2010)
  - **FIRST OPTION RENEWAL AND AMENDMENT:** (October 2010)
    - Exercise first one-year renewal option (Year 4)
    - Add \$3.1m for Year 4
    - Add a third optional renewal year to the contract (for a total potential of 6 years)
  - **SECOND OPTION RENEWAL AND AMENDMENT:** (October 2011)
    - Exercise second one-year renewal option (Year 5)
    - Added \$4.9 m for year 5
  - **THIRD OPTION RENEWAL AND AMENDMENT:** (October 2012)
    - Exercise third and final one-year renewal option (Year 6)
    - Added \$5.5m for year 6
    - Contract Total: \$20.5 m for 6 years
  - **SOLE SOURCE CONTRACT (October 2013)**
    - One year term (through October 2014)
    - Value: \$4.4m (20% reduction from the prior year contract amount of \$5.5m)

# Vendor Selection



- Decision to initiate RFP process
  - When HHC first started Breakthrough few competitors with Simpler; the field is larger now
- 43 companies received RFP
- 6 companies submitted formal proposals
- Selection Committee evaluated all 6 proposals
  - 3 respondents participated in interviews
- Committee completed final written evaluation/scoring
- Simpler ranked highest against all other proposals

# New Contract



**Period:** November 1, 2014 through October 31, 2017 (3 years)

**Contract Amount:** \$10,494,000.

CY 2015= \$4,404,000

CY 2016=\$3,323,500

CY 2017=\$2,766,500

(CY 2017 amount is 37% less than CY 2014 contract amount)

**Projected Financial Return:** For every \$1 spent on this contract, HHC will collect and report \$ 20.49 in new revenues and cost savings.

# Partnership with Simpler

	Simpler	Purpose	HHC
VISION AND STRATEGY	Teach/coach leadership on hoshin kanri	Set and align organizational strategy and business goals; establish approach for collaborative achievement	Adopt multi-year goals and plans for annual achievement
ARCHITECTURE AND INFRASTRUCTURE	Teach/coach Simpler Business System (SBS)	Establish a comprehensive system for setting vision, planning, managing, improving and sustaining gains in which all employees contribute to the mission and goals of the organization. Embrace development of people as a fundamental priority.	Modify SBS to create Breakthrough—the HHC Operating System; Create training and development programs.
VALUE STREAMS	Teach A3 thinking and tools --VSA, VVSM, RIE, 2P	Establish the approach and component parts of the operating system -- tools and processes.	Develop internal capacity for continuous and sustained improvement.
DAILY IMPROVEMENT	Teach and coach managing for daily improvement	Enable managers throughout HHC to operate through a standardized program of behaviors, tasks and administrative actions.	Develop and implement the Daily Management System with just in time modular expansions.

# HHC FY15 Goals



- Improve alignment of Breakthrough resources to strategic business goals
  - Deepen application of hoshin kanri
  - Identify enterprise-level strategic value streams
  - Establish enterprisewide measures and targets
  - Prioritize resource allocation
- Improve spread of best practices and sustainment of improvements
  - Establish and spread standard work (what good looks like)
  - Create process and repository for use of tested and validated solutions (“Yokoten” repository)
- Embed Breakthrough expertise more broadly across the organization to grow independence from external expertise
  - Accelerate spread of DMS and model value streams
  - Spread capacity for Bronze and Silver training to facilities
  - Conduct leader and manager training
  - At least 4 (now 2) sites will rely only on the Enterprise Breakthrough Office for coaching and consultation

# Future Simpler Role (Contract Scope)

Utilizing the full bench strength of Simpler and Truven, deploy expertise to sites and the corporate office:

## ➤ Visioning and Strategy:

- Deploy lean Leadership Institute for senior leaders
- Coach leadership in hoshin kanri application
- Create innovation model

## ➤ Architecture and Infrastructure:

- Create a Human Development strategy
- Create model value streams in areas of strategic priority

## ➤ Value Stream Activity

- Ensure facility Breakthrough office staff and leaders have a deep understanding of Breakthrough, are expert on tools and techniques and can move easily between different applications
- Establish model value streams in areas of strategic priority
- Establish flow cells in all value streams
- Strengthen enterprise and site level analytic and evaluative capacity, including ROI

## ➤ Daily Management System

- Accelerate spread of DMS with the goal of implementing in 250 areas
- Add audit boards, leader standard work, “idea generation”

“The core work of the transformation is changing the culture---changing how we respond to problems, how we think about patients, how we interact with each other...When lean thinking goes only skin deep and management does not change, improvements cannot be sustained.”

John Toussaint, MD  
Founder and CEO  
Thedacare Center for Healthcare Value