

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

**OCTOBER 7, 2014  
10:00 A.M.  
HHC BOARD ROOM  
125 WORTH STREET**

**AGENDA**

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

**II. ADOPTION OF SEPTEMBER 9, 2014  
STRATEGIC PLANNING COMMITTEE MEETING MINUTES** **JOSEPHINE BOLUS, RN**

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

**IV. INFORMATION ITEM**

**i. KINGS COUNTY HOSPITAL CENTER'S EMERGENCY DEPARTMENT TRANSFORMATIONAL  
JOURNEY**

**MARIE-LAURE ROMNEY, MD  
ASSISTANT MEDICAL DIRECTOR/CLINICAL ASSISTANT PROFESSOR  
DEPARTMENT OF EMERGENCY MEDICINE, KCHC**

**V. OLD BUSINESS**

**VI. NEW BUSINESS**

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



## **MINUTES**

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

**SEPTEMBER 9, 2014**

The meeting of the Strategic Planning Committee of the Board of Directors was held on September 9, 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  
Bernard Rosen  
Patricia Yang, representing Deputy Mayor Lilliam Barrios-Paoli

##### **OTHER ATTENDEES**

K. Cherny, Unit Head, Office of Management and Budget  
J. DeGeorge, Analyst, New York State Comptroller  
T. DeRuben, Analyst, Office of Management and Budget  
M. Dolan, Senior Assistant Director, DC 37  
S. Newmark, Mayor's Office  
K. Raffaele, Analyst, Office of Management and Budget  
D. Woodrooffe, Analyst, Office of Management and Budget

##### **HHC STAFF**

P. Albertson, Senior Assistant Vice President, Operations  
M. Belizaire, Assistant Director of Community Affairs, Office of Intergovernmental Relations  
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, Corporate Planning Services

- E. Casey, Assistant Director, Corporate Planning and HIV Services
- D. Cates, Chief of Staff, Office of the Chairman
- L. Chang, Data Center Administrator, World Trade Center Environmental Health Center
- J. Chesser, Assistant Vice President, Intergovernmental Relations
- E. Davis, Senior Associate Director, World Trade Center Environmental Health Center
- L. Guttman, Assistant Vice President, Office of Intergovernmental Relations
- C. Jacobs, Senior Vice President, Patient Safety, Accreditation & Regulatory Services
- L. Johnson, Senior Assistant Vice President, Medical and Professional Affairs
- J. Jurenko, Senior Assistant Vice President, Intergovernmental Relations
- B. Keller, Deputy Counsel, Office of Legal Affairs
- Z. Liu, Senior Management Consultant, Corporate Planning Services
- P. Lockhart, Secretary to the Corporation, Office of the Chairman
- A. Marengo, Senior Vice President, Communications and Marketing
- R. Mark, Chief of Staff, President's Office
- A. Martin, Executive Vice President and Chief Operating Officer, President's Office
- I. Michaels, Director, Media Relations, Communications and Marketing
- T. Miles, Executive Director, World Trade Center Environmental Health Center
- J. Omi, Senior Vice President, Organizational Innovation and Effectiveness
- K. Park, Associate Executive Director, Finance, Queens Health Network
- C. Pean, Associate Director, Harlem Hospital Center
- S. Penn, Senior Director, World Trade Center Environmental Health Center
- L. Robinson, Administrator, World Trade Center Environmental Health Center
- W. Saunders, Assistant Vice President, Office of Intergovernmental Relations
- J. Wale, Senior Assistant Vice President, Behavioral Health
- K. Whyte, Senior Director, Corporate Planning, Community Health and Intergovernmental Relations
- R. Wilson, M.D., Senior Vice President, Corporate Chief Medical Officer, Medical and Professional Affairs

**CALL TO ORDER**

The meeting of the Strategic Planning Committee was called to order at 10:00 a.m. by the Strategic Planning Committee Chairperson, Josephine Bolus, NP-BC. The minutes of the July 8, 2014 meeting of the Strategic Planning Committee were adopted.

**SENIOR VICE PRESIDENT REMARKS****Federal Update**September 11 Health

Ms. Brown reported that both houses of Congress had returned from their five-week long summer break on September 8, 2014. Congress will remain in session for a total of three weeks before adjourning on October 2, 2014, to prepare for elections. Ms. Brown commented that the entire House and roughly a third of Senate seats were up for re-election. Ms. Brown informed the Committee that for HHC, a priority was the early re-authorization of the James Zadroga 9/11 Health and Compensation Act of 2010, which was scheduled to be introduced in Congress on September 8, 2014, by members of the New York State Congressional Delegation. Ms. Brown reminded the Committee that this law had authorized funding for HHC's World Trade Center Environmental Health Program (WTC EHC). Ms. Brown reported that staff of HHC's Office of Intergovernmental Relations (IGR), specifically Mrs. Judy Chesser and Mr. Leonard Guttman, had been working closely with the Congressional Delegation and Senator Gillibrand's staff on the language of the re-authorization bill. Ms. Brown noted that HHC had suggested several changes, which would not likely be included in the re-authorized bill. She explained that the objective of Congressional members was to have the re-authorized bill passed. Accordingly, Congressional members do not want to make significant changes. Ms. Brown added that one notable change in the new draft bill was the elimination of the requirement that all applicants for Zadroga benefits would be checked against the Terrorist Watch List. Ms. Brown explained that this was a change that HHC supported and had found problematic over the last three years. Given the political climate, including the possibility that the Senate may change hands from Democrat to Republican control, reauthorization of this bill was not guaranteed. Ms. Brown reminded the Committee that, as authorized by the Zadroga Act, HHC had been administering the 9/11 Survivor's health program over the past three years, and had also administered the grant funded program prior to passage of the Act.

U.S. Courts on Subsidies on Federal Health Insurance Exchange

Ms. Brown reported that, on July 22, 2014, two federal Courts of Appeals had issued conflicting rulings on the question of whether the federal government could provide subsidies when individuals purchase health insurance through the federal exchange. Ms. Brown explained that the federal health exchange operated the health insurance marketplaces of the 36 states that had declined to create their own state-run exchange. She added that the Affordable Care Act (ACA) did not explicitly state that the federal exchange could provide a subsidy. Ms. Brown explained that it had been clearly written into the law that state-run exchanges could provide such subsidies. The New York State Health Exchange will not be affected by the rulings. She commented that this split decision served only to add more conflict and confusion around this important health care reform effort, which may be brought before the Supreme Court. In the meantime, the Obama Administration has stated that it would continue to enforce the law's requirement that subsidies (i.e., Advanced Premium Tax Credits) must be paid by all exchanges. Ms. Brown added that nearly three-quarters

of New Yorkers who had enrolled in private health insurance through the state exchange were eligible for these subsidies.

### **Delivery System Reform Incentive Program (DSRIP) Community Needs Assessment Update**

Ms. Brown reported that the month of August had been a quiet month with no major updates to report on both the city and state fronts. She informed the Committee that she would provide an update on the body of work concerning the Delivery System Reform Incentive Program (DSRIP) Community Needs Assessment that HHC's Corporate Planning Services' Unit had been engaged in on behalf of HHC.

Ms. Brown reminded the Committee that the goal of DSRIP is to transform the health care delivery system in New York State through the development of primary, preventive and other healthcare strategies, which would result in a 25% reduction in avoidable hospitalizations by the end of the five year waiver period. In pursuit of that goal, DSRIP Participating Performing Provider Systems (PPSs) – healthcare organizations who take the lead in forming partnerships to operationalize specific DSRIP projects and meet those project objectives - must first develop an understanding of the current health care delivery and health-related ecosystem and most importantly, the healthcare needs of the communities in which these PPSs have proposed to assume responsibility. Ms. Brown added that PPSs will do that by conducting a comprehensive Community Needs Assessment (CNA) of their defined service areas, which would ultimately drive their DSRIP project selection process and investments.

Ms. Brown explained that the CNA must evaluate community need through primary and secondary data collection and analysis; identify health and health service challenges of a population in a particular geographic area; evaluate health care and other community resources; and identify major gaps between community need and current resources. Ms. Brown informed the Committee that, PPSs with whom HHC had partnered to conduct the CNA must provide documentation of the process; methods used to conduct the CNA; and must also provide baseline data and justification for project selection.

Ms. Brown reported that, over the course of the summer, HHC's Corporate Planning Services staff had been working in collaboration with several other non-HHC emerging PPSs in at least three boroughs to design, launch and conduct the primary data collection components of the CNA. This work is being conducted through contract arrangements with the New York Academy of Medicine (NYAM) and Tripp Umbach, specifically to collect information about health care priorities, unmet needs, perceptions of available primary health care services, barriers to accessing health care and health care services utilization. Ms. Brown reported that HHC facilities and the collaborating PPSs would ensure community engagement in the CNA process through community surveys of the population (i.e., surveys will be offered in multiple languages), which would be administered by trained data collectors from community-based organizations. Ms. Brown informed the Committee that HHC's goal was to collect a minimum of 600 in-person surveys per borough. She added that a total of 20 to 25 focus groups would also be conducted that would be focused on target issues (e.g. mental health, substance abuse etc.) or on specific targeted population groups (e.g. persons with disabilities, or children and adolescents, etc.) that were identified by the collective PPS' facility leadership and key CBO partners. Ms. Brown highlighted that focus groups with HHC CAB members had already begun and would continue through mid-September. Additionally, HHC has made contact with labor representatives such as the New York State Nurses Association (NYSNA), the Doctors Council SEIU and with colleagues from District Council 37 to confirm dates to conduct focus groups with nurses, doctors and residents. These focus groups will be completed by the end of September.

Ms. Brown informed the Committee that, in addition to focus groups, a total of 10-15 key informant interviews of provider, community members and community leaders had been conducted per borough to further identify health care priorities, gaps in service and unmet needs. These key informants were identified collectively by the collaborating PPS' in each borough. Ms. Brown acknowledged Ms. Dona Green, Senior Assistant Vice President, Corporate Planning Services and her team for their efforts in working on this exhaustive process.

Ms. Brown reported that HHC would also gather secondary data including community demographics, community resources, community provider inventory and population health status data through sources including but not limited to the US Census American Community Survey, NYC Department of City Planning, New York City and State Departments of Health, the Center for Health and Workforce Studies, the Greater New York Hospital Association and other sources.

Ms. Brown reported that HHC had a very ambitious timeframe, and that the CNA process was projected to be completed by September 30th. She further explained that the completion of the CNA process would help to further guide discussions in terms of identifying potential PPS partnerships that may be needed to fill gaps identified as a result of the CNA. Ms. Brown stated that HHC's goal was to finalize its PPS partner list by early November and to submit its DSRIP Project Plan application by the December 16, 2014 due date. Ms. Brown concluded her report by announcing that assessor recommendations on HHC's DSRIP Project Plan were expected in early February 2015, and DSRIP awards would be announced in early March 2015.

Ms. Brown clarified that HHC's DSRIP Project Plan application must be submitted by December 16, 2014. Mr. Rosen, Board Member, expressed his concern that this was a difficult process. Ms. Brown explained that the needs assessments were needed to inform decisions on what would be significant investments of state and federal funds throughout the state and in the city. If the state holds true to providing oversight of the formation of PPSs along with the implementation of specific projects, this would address identified gaps and communities would be better served. Ms. Brown agreed that the CNA process was a lot of work but very important. Ms. Brown added that funds would begin to flow in March 2015.

## **INFORMATION ITEM**

### **World Trade Center Health Program Update**

Terry Miles, Assistant Vice President, HHC's World Trade Center Environmental Health Center

Mrs. Bolus introduced Terry Miles, Assistant Vice President and Executive Director for HHC's World Trade Center Environmental Health Center (WTC EHC) Program. Mr. Miles thanked the Committee for the opportunity to present an update on the World Trade Center Health Program. Mr. Miles began his presentation by first inviting Committee members and invited guests to attend a patient Therapeutic Art Exhibit at Bellevue Hospital Center. Mr. Miles explained that the exhibit was an annual event that would be available for viewing through Friday, September 12, 2014. Mr. Miles added that exhibit was the only planned public event for the 13<sup>th</sup> anniversary of the 9/11 Terrorist Attacks because all sites had been focused on retention activities throughout the past year.

Mr. Miles presented the new official new logo of the World Trade Center Health Program (WTC HP) to the Committee (listed on front page of the presentation package). Mr. Miles provided the Committee with an overview of his presentation as outlined below:

- Timeline of WTC-Related Care and Funding
- The James L. Zadroga 9/11 Compensation Act
- Who we are and what we do
- Who we serve
- Program changes Pre and Post Zadroga
- Revenue and Expenses
- Reauthorization of the Zadroga Act

Mr. Miles reminded Committee Members that the World Trade Center Environmental Health Center Program (WTC EHC) was housed within HHC's Central Office Division of Corporate Planning, Community Health and Intergovernmental Relations, which is led by Ms. LaRay Brown. Mr. Miles explained that this placement within the Corporate Planning Division made sense because the WTC Health Program was a very high profile program at all levels of government including at the federal, state and local levels. He added that throughout the program's history, every one of those levels of government had taken the lead. There are a lot of interactions with elected officials, and there have been a tremendous amount of planning and adjustment as the program has evolved. Regarding community health, the WTC EHC is all about health.

Mr. Miles provided a timeline of the WTC Health Program and funding as described below:

- Within the first few weeks after 9/11, patients started showing up at HHC facilities; specifically at Bellevue Hospital Center stating that the cough that they were experiencing had to do with how they were exposed on 9/11. Bellevue's Pulmonary Health Clinic provided community screenings in the field. Bellevue/NYU Hospital's Asthma Program began the first study of adverse health outcomes among local residents. As a result, Dr. Joan Reibman, WTC EHC's Medical Director, and other physicians within the HHC system, commandeered HHC's Asthma Van to go into the affected communities to begin a needs assessment of those communities. As a result, contacts were made with community based organizations (CBOs) and advocates who were also concerned about the adverse health outcomes in local residents. Very gradually since then, the WTC patient census started to grow.
- **In early 2002:** With the support of philanthropic organizations such as the Robin Hood Fund and the 9/11 Fund, 200- 400 patients started coming into the WTC Program. All of these patients were being seen in the Adult Asthma Program at Bellevue Hospital as well as other HHC facilities. In and around Elmhurst Hospital in Queens, Irwin Berlin, M.D., the former Pulmonary Director, through his own community outreach efforts identified a cohort of patients, primarily Spanish speaking women, who had worked as cleanup workers in and around the WTC sites and who were now ill. Dr. Berlin started a small WTC healthcare focus group in 2005. Attention to this issue grew in various areas throughout HHC such as Gouverneur Diagnostic and Treatment Center.
- **In 2005:** More significant funding started to flow. Mr. Miles acknowledged, Ms. Deborah Cates, Chief of Staff, Office of the Chairman of the Board of Directors, for her lobbying efforts and advocacy with various organizations. Funding provided by the American Red Cross Liberty Disaster Relief Fund of \$2.4 million allowed the WTC program to gel.



- **In 2006:** the Federal Government for the first time began to provide funding for people who had been identified as having 9/11-related illnesses. Mr. Miles noted that, prior to 2006 the Federal Government had provided funding only for screening and monitoring for the Responder population. If people were sick, they had to find care wherever that might be, which generally meant within HHC. Also in 2006, the City of New York felt that it was a major oversight that this particular program that was being administered by HHC and provided care to the community had not been acknowledged. In 2006 and 2007, HHC received funding from the City of New York, the New York Times' Neediest Fund, and the New York Community Trust to open a clinic at Gouverneur Diagnostic and Treatment Center and to expand the care programs at Bellevue and Elmhurst Hospitals.
- **In 2007 and 2008:** Heavy lobbying activities were launched with then Senator Hillary Clinton serving as a big supporter of the bill. As a result of her efforts, in 2008, the program received appropriations funding. Mr. Miles noted that, over the following three years, the WTC EHC program was funded jointly by the federal government, the city and through ongoing philanthropic efforts.

Also 2008, HHC received Non-Responder Grant funding from the National Institute of Occupational Safety and Health (NIOSH)'s to provide services at all three sites. Additionally, HHC received funds from the City of New York to support outreach contracts with community-based organizations and labor groups.

- **In 2009-2010:** Tremendous efforts were taken to pass the Zadroga bill. In 2010, Congress passed the Zadroga 9/11 Health and Compensation Act of 2010, which created the World Trade Center Health Program (WTCHP).
- **At the start of 2011:** The Zadroga Act was signed into law by President Obama on January 1, 2011. NIOSH awarded HHC contracts for the WTCHP Clinical Center of Excellence and Data Center Programs to serve 9/11 Survivors. Mr. Miles clarified that James Zadroga was the first person to be documented as having died from exposure to 9/11 related toxins, which was the reason why the bill was named in his honor. The Act is administered by NIOSH, part of the division of the Centers for Disease Control and Prevention, which sits within the Department of Health and Human Services of the Federal Government.

Mr. Rosen, Board Member, asked if an individual had to be enrolled in one of the WTC health programs in order to receive benefits from the Victim's Compensation Fund. Mr. Miles responded no. He clarified that the Victims Compensation Fund (VCF) was a separate program and that VCF applicants do not have to be part of HHC's WTC Health Program. However, individuals who are not part of the WTC Health Program would have to provide a great deal of onerous paperwork to demonstrate how they were exposed on 9/11.

- **In 2012:** NIOSH expanded the list of WTC-related health conditions to include certain cancers that would be treatable under the WTCHP. Additionally, Hurricane Sandy closed Bellevue Hospitals for 99 days and shifted clinical services to Gouverneur and clinical administrative services to Central Office.
- **In 2013:** WTC EHC enrollment surged due to the registration deadline for the VCF.

- In 2014: Re-authorization of the Zadroga Act remains pending

Mr. Miles reported that the James L. Zadroga 9/11 Health and Compensation Act of 2010 became operational on July 1, 2011. He added that the Zadroga Act was administered by NIOSH and the Centers for Disease Control (CDC). The WTCHP provides medical and mental health services for WTC Responders and community members who became ill due to the aftermath of the 9/11 Terrorist Attacks.

Mr. Miles described the WTCHP as comprising:

- A total of seven (7) Clinical Centers of Excellence (CCEs) located within the New York City area. Although HHC’s WTC EHC is considered a single CCE, there are three sites, which are located at Bellevue and Elmhurst Hospitals and at Gouverneur Healthcare Services.
- A National Program which serves individuals who live throughout the United States including Responders who aided with the attacks on the Pentagon and the crash in Shanksville PA. Mr. Miles reported that WTC related health care was being provided across the United States in 431 Congressional districts. Ms. Brown commented that, having WTC-related health care services within 431 Congressional districts was helpful for the reauthorization of the law.
- Three (3) Data Centers (DCs)
- NYC Department of Health and Mental Hygiene WTC Registry
- Advisory Committees

Mr. Miles reminded the Committee that the WTC EHC served only Survivors. He explained that the Survivor’s program was a legislatively created term to distinguish that aspect of the program from the Responder program. Mr. Miles described both programs as outlined below:

Survivors	Responders
<ul style="list-style-type: none"> <li>• Patients have to be sick before coming to the program. WTCHP does not screen healthy individuals.</li> </ul>	<ul style="list-style-type: none"> <li>• Screen healthy individuals for potential illness to evolve overtime.</li> </ul>
<ul style="list-style-type: none"> <li>• No out-of pocket costs. Patients existing insurance are billed first and leftover unpaid monies from these insurance companies to the Federal Government.</li> </ul>	<ul style="list-style-type: none"> <li>• Free. The Federal Government is considered the payer for care and services rendered to responders.</li> </ul>
<ul style="list-style-type: none"> <li>• 50/50 split of men and women and children are included</li> </ul>	<ul style="list-style-type: none"> <li>• Almost entirely men but no children</li> </ul>
<ul style="list-style-type: none"> <li>• Shares the same illnesses with Responders</li> </ul>	<ul style="list-style-type: none"> <li>• Share the same illnesses with Survivors</li> </ul>

Mr. Miles reported that a National Survivor Program that was authorized as part of the Zadroga Act had been recently established. He informed the Committee that Survivors were now accessing WTC-related health care services in 221 Congressional districts across the United States. Mr. Miles informed the Committee that the Advisory Survivor Steering Committee had been a very involved group made up of constituents. In addition, the Scientific and Technical Advisory Committee (STEC) is made up of seven

physicians and eight lay persons. He added that the STEC advocated for the expansion of the list of WTC-related conditions to include certain cancers. Ms. Brown commented that, from the very beginning, HHC had been working with individuals including community-based organizations (CBOs) and advocates, and labor partners who comprised the Survivor Steering Committee. Mrs. Brown acknowledged Ms. Judy Wessler, the former Director of the Commission of Public Health System for her efforts. Ms. Wessler, along with several community-based organizations, particularly those who provide services and advocacy for residents in the lower Manhattan area, were involved in bringing to the attention of Dr. Reibman and others, some of the health care concerns of residents. They worked with HHC to formulate its initial response and to ensure that Survivors were not forgotten as part of the federal response.

Mr. Rosen inquired about the longevity and if the Act was scheduled to sunset. He informed the Committee that, serving as a member of the City's Audit Committee, he learned that the World Trade Center Captive Insurance Company, which started with \$1 billion, had a sunset date far into the future. He asked if the bill was reauthorized, how long it would remain in effect. Mr. Miles responded that the current Zadroga Act was scheduled to sunset in October 2016. Notwithstanding, the government established contracts that were scheduled to terminate on June 30, 2016.

Mr. Rosen expressed some concern about the sunset of the law as more potential victims could be identified in the future. Mr. Miles responded that a request for an additional 25 years was included in the re-authorization of the bill, which would extend the program to 2041. Mr. Miles acknowledged the Chairperson of the Survivor Committee, Ms. Kimberly Flynn, for her advocacy on behalf of the WTC EHC program.

Mr. Miles presented members of the WTC EHC's Management Team who were present at the meeting. Team members included:

- Scott Penn, Deputy Director
- Edith Davis, Data Center Director
- Larry Chang, Administrator
- Lance Robinson, Administrator

He added that the WTC EHC's Management Team also included the Medical and Mental Health Directors at the clinical locations. They are:

- Joan Reibman, MD, Medical Director
- Nomi Levy-Carrick, MD, Mental Health Director

Mr. Miles acknowledged Mrs. Judy Chesser and Mr. Leonard Guttman, for playing a very key role in getting the law passed. He also acknowledged Mr. John Jurenko and Mrs. Wendy Saunders who had also advocated for the program. Mr. Miles added that most of the staff of HHC's Corporate Planning Division had provided support to the WTC EHC program, and he expressed his thanks. Mr. Miles also thanked staff within other HHC departments including Legal Affairs, Finance, Compliance, Public Affairs and IT who had also provided support to the WTC EHC. Lastly, Mr. Miles acknowledged Dr. Raju, HHC's President for the key role that he played with supporting the WTC EHC program from its inception.

Mr. Rosen asked if the program was responsible for informing potential victims who receive care at HHC's WTC EHC sites about how to obtain financial assistance. Ms. Brown responded that the WTC EHC program provided health care services to Survivors. However, as part of the intake process, it is expected that the individual would obtain information about the entire program, which included the Victims Compensation

Fund. Ms. Brown emphasized that the WTC EHC program does not screen healthy people. Therefore, individuals presenting to these centers must have symptoms related to a WTC-approved condition. Mr. Miles added that it was the WTC EHC's mission to educate people about other issues such as insurance, Worker Compensation, etc.

Mr. Miles stated that the actual work of the WTC EHC occurred at three HHC facilities including Bellevue and Elmhurst Hospitals and Gouverneur Diagnostic and Treatment Center (D&TC). He described HHC's WTC EHC as the following:

- The only World Trade Center Health Program Clinical Center of Excellence for Non-Responders
- It provides health care for local workers, residents, children, passersby and clean-up workers below Canal Street in Manhattan and the Brooklyn Heights waterfront
- It is a multidisciplinary treatment program for individuals with WTC-related illnesses
- Patients incur no out-of-pocket expenses for treatment at the WTC EHC
- Medical and mental health conditions must be first "certified" by NIOSH for a patient to continue treatment

Mr. Miles reported that there were 7,735 patients who were currently enrolled in the WTC EHC. Of that total, 4,055 are active patients. NIOSH defines active patients as those patients who have had at least one visit within the past three years. Mr. Miles added that overwhelmingly, most patients have been seen more recently than the past two years. The distribution of HHC WTC EHC patients at the three HHC program sites is the following:

- Bellevue Hospital: 67%
- Elmhurst Hospital: 9%
- Gouverneur Diagnostic & Treatment Center: 24%

Mr. Miles stated that, over the past year, there had been a huge push to recruit and enroll Survivors into the WTCHP, which benefited from outreach and awareness initiatives that promoted the application deadline for the Victim Compensation Fund. He reported that, from August 2013 to August 2014, nearly 1,200 Survivors were enrolled compared to only 500 for the prior year. Mr. Miles informed the Committee that new patients were still being enrolled into the program. On average, 100 new patients are enrolled every month.

Mr. Miles reported on the demographics of the WTC EHC patient population. He explained that there was a 50/50 split between men and women. He added that 28 of the 95 patients that entered the program at age 18 years or younger had aged out of the pediatric program and had been transferred to the adult program. It is expected that, as time goes on, the pediatric program would eventually be phased out. Currently, the average age of children in the pediatric program is 15 years old.

Mr. Miles described the current certified conditions of patients served by the WTC EHC as the following:

**CURRENT CERTIFIED CONDITIONS**

<b>Certified Condition</b>	<b>% of Patients with Certified Conditions</b>
<b>Medical Conditions</b>	
Obstructive airway disease	51%
Upper respiratory disease	39%
Gastroesophageal reflux disease	38%
Cancer	6%
Interstitial lung disease	1%
Sarcoidosis	1%
<b>Mental Health Conditions</b>	
Post-traumatic stress disorder	22%
Adjustment reaction	21%
Depression	20%
Anxiety	13%
Substance Abuse	5%

Mr. Miles reported that, with the addition of certain cancers, 70 more additional conditions could be legally treated by the WTC EHC program. Mr. Miles stated that most patients have a combination of various certified medical conditions associated with mental health conditions. In addition to having patients who are becoming severely ill patients (i.e., patients who require lung transplants and some who have died), most patients will be chronically ill for the rest of their lives, but will be able to manage their conditions through the WTC EHC program. Mrs. Bolus asked how many generations would the program follow. Mr. Miles responded well into the future. He emphasized that an additional 25 years was included in the re-authorization bill.

Mr. Miles described the WTC EHC program cancer certifications as outlined on the chart below:

**CURRENT CANCER CERTIFICATIONS**

<b>Cancer Type</b>	<b># of Patients with this Cancer Certification</b>	<b>% of Patients with any Cancer Certification</b>
Breast	52	20%
Thyroid	33	13%
Lymphoma	32	12%
Trachea, Bronchus and Lung	29	11%
Prostate	26	10%
Head and Neck	20	8%
Leukemia (Lymphoid and Myeloid)	20	8%
Skin	19	7%
Multiple Myeloma	17	6%
Kidney	13	5%
Colon and Rectum	12	5%
Bladder	11	4%
Other	39	15%

Mr. Miles reported that the top cancer related certified condition for the WTC EHC program was breast cancer. For the Responder program, the top cancer related certified condition was Prostate Cancer.

Mr. Miles presented a side by side comparison of how the WTC EHC program worked prior to the Zadroga Act and post Zadroga focusing on areas including: eligibility and outreach, enrollment and certification, claims processing, and funding and reporting. This analysis is described in the following charts:

## 1. Eligibility and Outreach

	Pre-Zadroga	Post-Zadroga
Catchment area	Manhattan south of 14 <sup>th</sup> Street and Northwest Brooklyn	Manhattan south of Houston Street and Brooklyn Heights waterfront (11201)
Survivor Programs	WTC EHC was program where "Non-Responders" could receive care supported by Federal funds	National Survivor Program provides care for "Survivors" (Non-Responders) living outside of the New York Metropolitan Region
Pediatric services	Pediatric services were unique to the WTC EHC and allowed children of Responders to receive care	Children of Responders are excluded from the Survivor Program
Outreach	Using NYC Grant, HHC funded grassroots outreach through local community-based organizations and labor	Federal government funds outreach through an open contracting process nationwide

## 2. Enrollment and Certification

	Pre-Zadroga	Post-Zadroga
Enrollment	WTC EHC managed enrollment locally using a streamlined and exposure-specific intake assessment	Federal government manages enrollment using: <ul style="list-style-type: none"> <li>• Legislatively mandated exposure requirements;</li> <li>• Extensive documentation including "proof"; and</li> <li>• Enrollees must pass Terrorist Watch List</li> </ul>
Condition Certification	WTC EHC physicians determined the WTC-relatedness of patients' conditions within the dynamics of the clinical visit based on type of condition and temporal sequence.	Each WTC-related condition must be certified by the WTCHP before treatment can be reimbursed. Certification requires submission of complex form that details: <ul style="list-style-type: none"> <li>• Exposure history;</li> <li>• Time of onset of each symptom; and</li> <li>• Physician attestation</li> </ul>

### 3. Claims

Pre-Zadroga	Post-Zadroga
Federal government treated Survivors and Responders the same way vis-à-vis support for direct care	Direct care for Survivors must be billed to Third Party Payers first while direct care for Responders is only billed to the WTCHP
Federal funding supported the costs of providing WTC EHC direct care services and all visits to the WTC EHC were eligible for reimbursement	WTCHP pays for a direct care visit only if one of the visit diagnoses is for a WTC Certified Condition and/or a permissible visit category*
HHC invoiced the Federal government for direct care via line items in a grant budget	HHC first files claims to any Third Party Payer the patient may have and then to the WTCHP after Third Party Payer responds

\*The WTCHP is the only Federal health program that requires a match between a claim and a certified condition in order to bill.

### 4. Funding and Reporting

	Pre-Zadroga	Post-Zadroga
Funding source	WTC EHC funded by grants from City of New York and Federal government	WTC EHC has four funding streams: <ul style="list-style-type: none"> <li>• WTCHP Clinical Centers of Excellence Contract</li> <li>• WTCHP Data Center Contract</li> <li>• Fee for Service paid by Third Parties; and</li> <li>• Fee for Service paid by WTCHP</li> </ul>
Distribution of funding streams	Total program expenses – including direct care – supported by grants	Direct care is paid for by Fee for Service revenue with Zadroga the last payer in a coordination of benefits process
Reporting	One quarterly report and one quarterly invoice	<ul style="list-style-type: none"> <li>• Two monthly reports</li> <li>• Two monthly invoices; and</li> <li>• Frequent <i>ad hoc</i> reports</li> </ul>

Mr. Miles informed the Committee that the WTC EHC's monthly reports were so onerous that it took most of the month to complete them. In addition to the monthly reports, there are roughly 30 different ad hoc reports including:

- Cancer drug exclusion reports to make sure that the WTCHP pays only for prescriptions for certified conditions for cancer patients
- Monthly WTC claims spreadsheets
- Internal audit reports
- Workers Compensation reports
- Appointment wait time reports

Mr. Miles reported on some of the administrative changes that were made to the WTC EHC program. These changes are described below:

- The Federal government made the decision that cancer care could take place outside of the CCE construct
- The WTCHP is considering moving to a fixed price contract model
- The WTCHP application is being revised – including removal of the government ID request
- Quality Assurance review criteria decreased from 22 items to 8
- Correction by the WTCHP to include musculoskeletal coverage
- The WTCHP's liaisons to HHC (the Contracting Officer and Contracting Officer's Representative) have changed three times over the past three years

Mr. Miles commented that, every time the WTC EHC's federal liaison changed, new reporting requirements were added. As such, the program has consistently remained in adjustment mode. He emphasized that, one good decision that the federal government made was allowing for cancer care to be provided outside of the Clinical Center of Excellence. This decision means that the federal government respects other institutions including Memorial Sloan-Kettering and other cancer institutions where cancer patients seek care. Consequently, there was a need for the WTC EHC to develop a relationship with a Third Party Administrator called HealthSmart to help oversee cancer related care that are rendered outside the HHC system.

Mrs. Bolus asked if a separate department had been assigned to oversee care rendered outside the HHC system. Ms. Brown responded that all of this work was being done with the WTC EHC staff that Mr. Miles had presented earlier, with a lot of support from Finance and Reimbursement staff, such as Maxine Katz, Senior Assistant Vice President and Fred Covino, Assistant Vice President, Corporate Budget. Ms. Brown added that HHC's Finance and Reimbursement staff was critical in helping to create these reporting structures that were very different from Medicare and Medicaid billing processes. Mr. Miles acknowledged Ms. Barbara Keller, for her contribution in helping to establish the Third Party Administrator contract with HealthSmart to oversee cancer-related care. Mr. Miles commented that "it does take a village."

Ms. Brown reminded the Committee that the goal was not to create a huge administrative infrastructure or burden to the Corporation with a large Central Office operations because the program does not pay for it. She reminded the Committee that the program only paid for services rendered to patients through the program. Ms. Brown reassured the Committee that it was a conscious decision that was made for most of the program's funding to be used for health care services delivery and to support the clinical staff at the three HHC program sites.

Mrs. Bolus asked if there was a publication for public distribution that provided a comparison of the program pre and post Zadroga with reasons why the law needed to be reauthorized. Ms. Brown answered that the Corporation had been working with various elected officials who needed to know and who would be advocating for the bill's re-authorization. She informed the Committee that when the Zadroga Act was first enacted, the Corporation had started to think about its re-authorization. Ms. Chesser uses program information such as the number of patients served and other information to support her advocacy. Ms. Brown informed the Committee that HHC had a long list of suggested changes to the bill. Ms. Brown added that HHC's Communications Department had been reaching out to the public about the availability of services offered at the three HHC program sites.

Mr. Rosen asked if there was a dollar amount that was included in the re-authorization bill. Ms. Chesser answered that a total of \$1 billion was included in the bill for all seven Clinical Centers of Excellence. She restated that the new bill would extend the program through 2041. However, the Congressional Budget



Office has not yet scored the bill. She explained that the new re-authorization bill included language that stated that the program would continue in the same manner over the next 25 years. She also highlighted that the actual dollar amount in the bill was more than what was needed. Ms. Brown clarified that the dollar amount that was included in the bill was more than what had been drawn down.

Mr. Rosen asked for clarification concerning the musculoskeletal issue. He asked about treatment for individuals who had suffered from broken limbs as a result of the 9/11 Terrorist Attacks. Mr. Miles responded that there are some administrative corrections that are currently in the process of being addressed. If these changes do not happen, these administrative corrections would then be included in the re-authorization bill. One correction is the provision of coverage for injured individuals. Mr. Miles stated that it was an oversight that these injuries were not covered under the current bill for both Responders and Survivors. Mr. Miles informed the Committee that this correction would be handled administratively.

Mr. Miles reported that another unintended consequence of the bill concerned the payer mix. Mr. Miles described the WTC EHC Program's payer mix as the following:

- 30% of patients enrolled in Medicaid
- 30% of patients enrolled in commercial insurance
- 26% of patients with WTCHP coverage only
- 12% of patients enrolled in Medicare
- 2% of patients enrolled in Workers Compensation

He explained that the original intent of the Zadroga Act was for the WTC Health Program to serve as the payer of last resort for Survivors, and the first and only payer for Responders. As a result, the private health insurance plans of WTC EHC participants are billed first for care provided by the program. Mr. Miles informed the Committee that 26% of HHC's WTC EHC program participants were uninsured and undocumented (undocumented individuals can receive care through this program), and 30% are enrolled in the Medicaid program. Mr. Miles explained that, because Medicaid is the payer of last resort in New York State, the care rendered to these patients can never be billed to the WTC Health Program. Mr. Miles added that New York State had a pre-existing arrangement with the Federal Government, prior to the Zadroga Act that called for the Medicare program to be billed first and Medicaid last. Mr. Miles emphasized that this was an unintended consequence of the bill. However, it was unlikely that this issue would be corrected.

Mr. Miles reported the WTC EHC's revenue and expenses for Fiscal Year 2014 as the following:

<b>Revenue</b>		<b>Expenses</b>	
<b>Item</b>	<b>Amount</b>	<b>Item</b>	<b>Amount</b>
CC Contract	\$5,111,012	All CCE Services	\$4,560,564
DC Contract	\$1,252,577	All DC Services	\$1,252,577
FFS Revenue	\$1,061,301	Direct Care	\$1,351,163
<b>Total Revenue</b>	<b>\$7,424,890</b>	<b>Total Expenses</b>	<b>\$7,164,304</b>

Mr. Miles reported that the cost of running the WTC EHC program was more than \$7 million per year. He added that there was an equal amount of revenue to support the program. Mr. Miles explained that contract dollars also supported clinical services such as social work and case management as well as administrative services such as program management and claims processing. The Fee-for-Service (FFS) revenue supports physicians/other providers, and also cover care provided to patients. Mr. Miles reminded the Committee that these figures were preliminary and that the underlying surplus would dissipate as

revenue and expenses balanced out at the end of the fiscal year. Mr. Miles reassured the Committee that the WTC EHC staff was confident that they would be able to continue to show that the program pays for itself through this funding stream.

Mr. Rosen commented that one would think that the direct care cost would be larger than other administrative cost. Ms. Brown responded that some direct care costs were included in the other categories. Mr. Miles added that some contracts also supported social work, case management and other aspects of clinical care. Mr. Miles also explained that a key factor that impacted the direct care amount had to do with the reimbursement levels of payers in addition to unpaid Medicaid claims (30%).

Mr. Miles described some of the changes that were being requested to be included in the re-authorization bill as the following:

Pre-Zadroga	Post-Zadroga	Requested Changes in Reauthorization
No Terrorist Watch List requirement	Terrorist Watch List verification requirement	Requesting that Terrorist Watch List requirement be removed
Local patient travel assistance available with non-Federal funds for hardship cases	No federal funds available for local patient travel assistance	Requesting federal funds to be available for patient travel coverage in hardship cases
Year to year federal appropriations and time-limited philanthropic funds	Authorization for 5 years	Requesting authorization through 2041
Competitive proposals for philanthropic and grant funds – supplemented by City of New York dollars	CCE and DC funding required competitive proposals in response to government RFP	Requesting that no competitive proposals from current CCE and DC contract holders be required

Mr. Miles explained that the elected officials’ goal was to submit a clean re-authorization bill. As a result, it is unlikely that the requested changes would be included with the exception of adding additional monies for research.

Ms. Chesser informed the Committee that there had already been some indication that two of the recommended changes would not be granted. The first is the recommendation to grandfather current contracts. She explained that those who oppose the bill would think that grandfathering current contracts would circumvent procurement procedures. The second is transportation funding for needy patients. Ms. Chesser explained that, even though this request was only for a small amount of funding, it would not be granted because the goal was to put forth a bill with no new cost.

Ms. Chesser reported that currently the bill called for \$431 million in funding per year for the entire World Trade Center Program, which would include the health programs and the Victims Compensation Fund. This amount would be for each year until 2041. Legislators anticipate that the re-authorization bill would receive a good Congressional Budget Score because all of the available funding under the current bill has not been fully drawn down. Ms. Chesser commented that only the Congressional Budget Office understood how they would logically address numbers. She added that the score would be brought to the two houses where some opposition was expected.

Ms. Chesser stated that the current bill was set to expire in June 2016. Due to the expectation that there would be significant challenges to getting the bill re-authorized, the process of reauthorization is starting now. She explained that starting a bill's re-authorization at such an early stage was unprecedented. The norm is for the process of bill re-authorization to begin five minutes before midnight on the expiration date.

Some of the anticipated challenges regarding the re-authorization of the Zadroga Act include the following:

- Democrats believe that the Republicans will take the Senate and that, if they do, Republicans would run both the House and Senate. To date, only 12 Republicans have ever voted for this program. Twelve additional Republicans, who wanted to go on record, voted both ways.
- Republicans' basic support for the Zadroga Act is very thin and that would include Graham and Peter King for example and a Congressman from New Jersey.
- If the Senate goes Republican, it would remain so in 2015 and 2016, with the projection that Democrats would retake the Senate in 2017. The WTCHP would then have a very thin timeframe between the end of the contract in 2016 and the Democrats returning in January 2017. That is the cliff hanger that all the advocates for the WTC program are trying to avoid.

Ms. Chesser informed the Committee that Senator Gillibrand had originally planned to introduce the bill on September 8, 2014, and if not, on September 11, 2014. She added that there were numerous drafts of the bill because the bill was constantly being changed. Notwithstanding, it is very straight forward. The only dramatic change would be to eliminate the Terrorist Watch List requirement.

Mr. Rosen asked if approval was needed from both the Senate and the House. Ms. Chesser responded affirmatively. She added that the bill would also have to be signed by the President.

Mr. Rosen asked if the \$7 million of cost that was presented earlier had been spent since July 1, 2011. Mr. Miles and Ms. Brown both clarified that the \$7 million represented the program's annual cost. Mr. Rosen commented that there had been \$21 million spent over the last three years. Ms. Brown clarified that the expenditures varied not only due to the number of patients who were enrolled in the program, which varied from year to year, but because the program had different funding streams over the years.

Mrs. Bolus thanked Mr. Miles for his presentation. She commented that the presentation was very clear and comprehensive.

Mrs. Bolus announced that it was Primary Day, an important day when individuals choose the representatives that they would like most to represent their community as elected officials. She urged everyone who had not yet voted to remember to do so this evening. Ms. Brown informed the Committee that her staff had been working with the New York City Campaign Finance Board along with HHC's Community Advisory Boards (CABS) to conduct extensive outreach to promote voter registration and the importance of voting during the primary election and the general election in November.

## **ADJOURNMENT**

There being no further business, the meeting was adjourned at 11:07 AM.



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# *Kings County Hospital Center*

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## *Emergency Department Transformational Journey*



**Executive Sponsor: Eric Legome, MD**

The image shows the exterior of the Kings County Hospital Emergency Department building at dusk. The building is a multi-story brick structure with large glass windows. The sky is a mix of blue and orange, suggesting sunset or sunrise. In the foreground, there is a grassy area and a paved walkway. The text "Kings County Hospital Emergency Department" is overlaid in the top left corner.

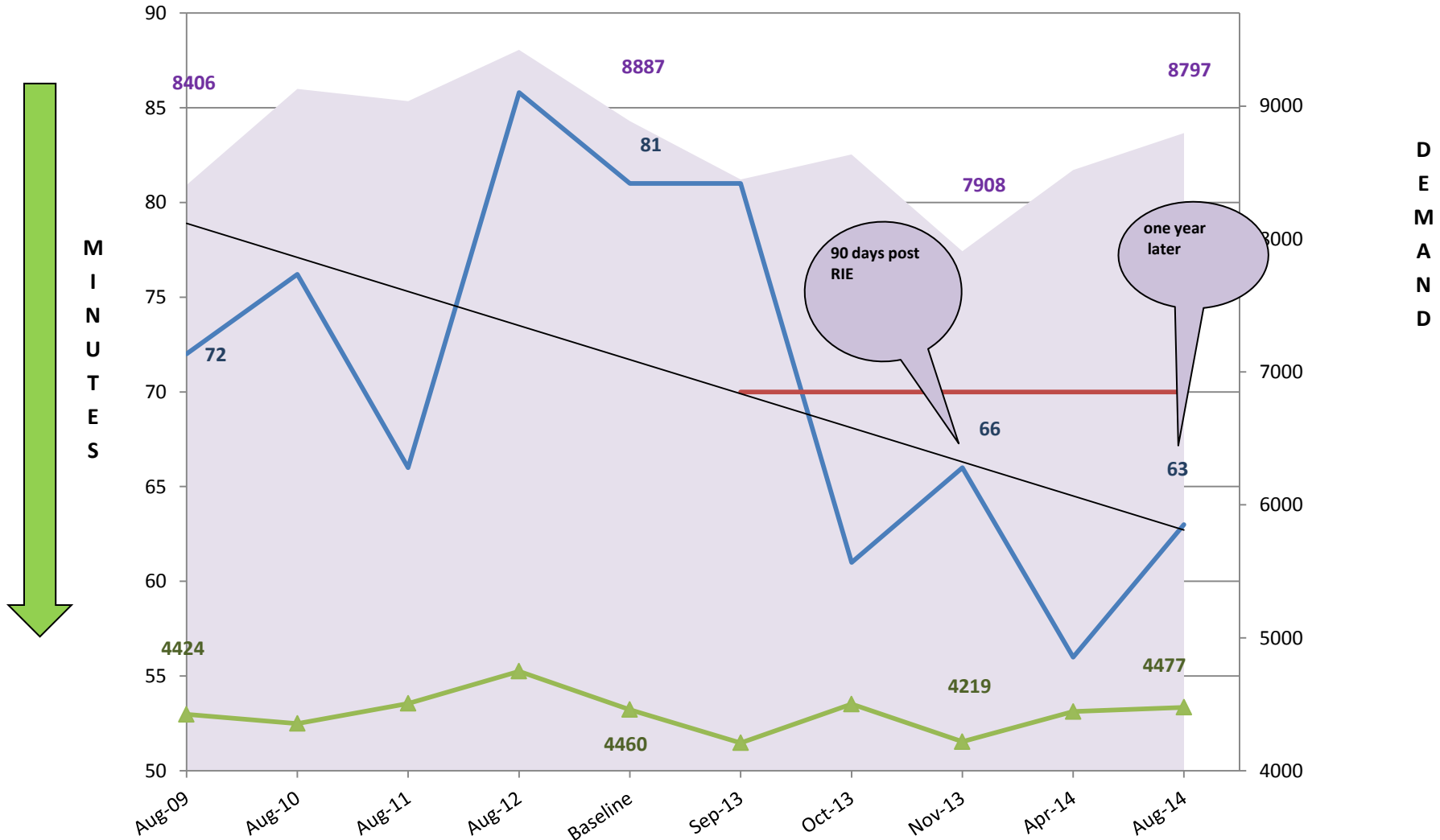
***Kings County Hospital  
Emergency Department***

- 140,000 visits each year
- Level 1 trauma center
  - ~1400+ trauma admissions (1/3 penetrating trauma)
- 12% Admission Rate, (15-20% of admissions to critical care setting)
- Stroke Center, Hypothermia Center, SART Center
- Teaching hospital with large EM residency, Peds EM fellowship and active research program

# Triage to Physician Assignment in the Adult Main ED (ESI 3)

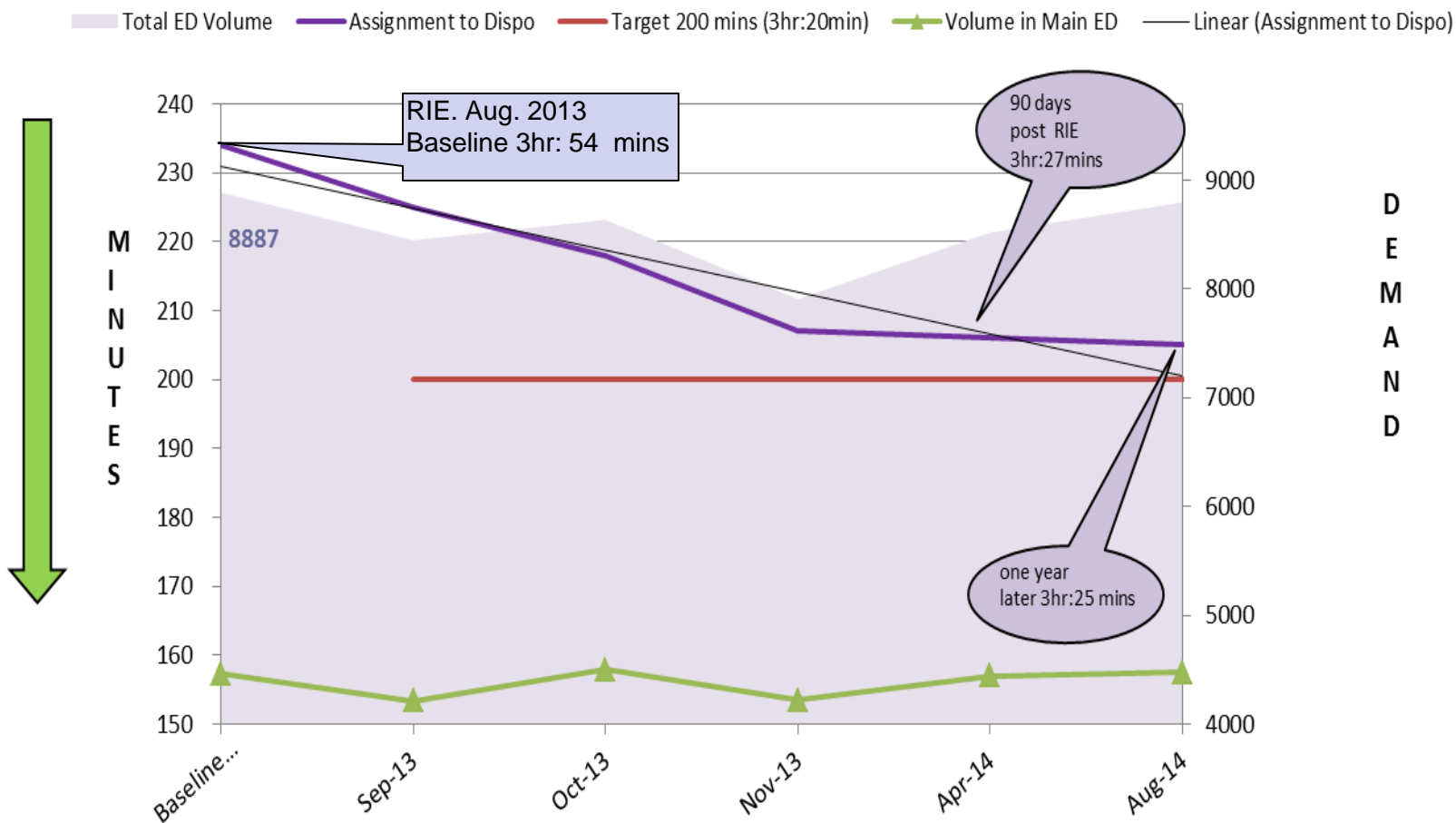


■ Total ED Volume 
 — Triage to Assignment 
 — Target 70 mins 
 ▲ Volume in Main ED 
 — Linear (Triage to Assignment)





## Minutes from Physician Assignment to Dispo in the Main ED (ESI 3)





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# *Kings County Hospital Center*

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*Emergency Department*  
***ED Treatment Flow***  
*Rapid Improvement Event*



**Marie Romney, Process Owner**

**August 19-23, 2013**

## Event Team

### Team Members:

1. Steve Malcome, RN, ED
2. Alfonso Stewart, PCA ED,
3. Cassandra Bradby, MD
4. Nagela Sainte-Thomas, MD Peds ED
5. Sanjean Philoxy, Asst. Dir. Pt. Relations

### Subject Matter Experts:

Dr. Peacock , Med Informatics  
Christopher Russo, Pharmacy

**Team Leader:** 6. Sonja Miller RN, ED

**Process Owner:** Marie Romney, MD

**Executive Sponsor:** Eric Legome, MD

**Facilitator:** Maritza Cales, Abra Havens

**Coach:** Claire Patterson, BDO

**Date: August 19-23 , 2013**



## Box 1: Reason For Action



*Patient flow within the Adult Emergency Department is fragmented, beginning with delayed check in and nursing assignment and postponements in initiation of treatment. This results in decreased quality of care, increased length of stay and inconsistent information exchange between clinicians, nurses and patients.*

### Boundaries

**Scope: Adult Main ED**

**Trigger: Empty bed available in Main ED**

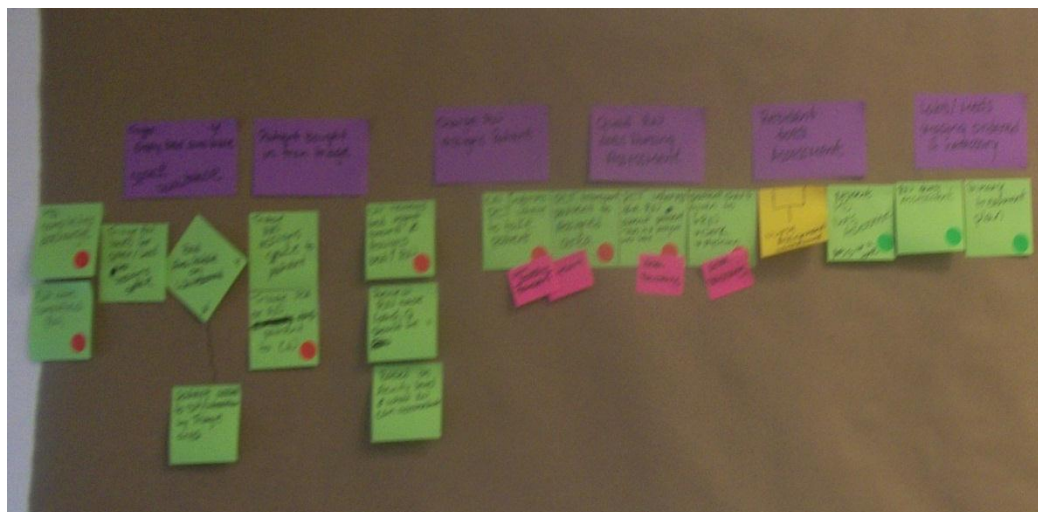
**Done: Primary Treatment plan initiated**

## Box 2: Current State



- Delayed check-in and assignment creates lags in Nurse/MD awareness of patient arrival to assigned bed. In addition, the bed assignment that is recorded does not always correspond with the patient's actual location.
- There are inconsistencies in implementation of standard work to manage the flow in the Main ED.
- There are delays in the initiation of care after the patient is evaluated and the plan of care is not consistently communicated to all treatment providers.

Measure	Pre-event
Human Development Breakthrough Engagement	151 (as of 7/3)
Timeliness/ Delivery Median Triage to Assignment (First Provider) from Control Charts	<b>81 minutes</b> <i>6 month median</i>
Timeliness/ Delivery Median Assignment to Disposition	<b>3:54 (h:mm)</b> <i>6 months median</i>



### Current State Attributes

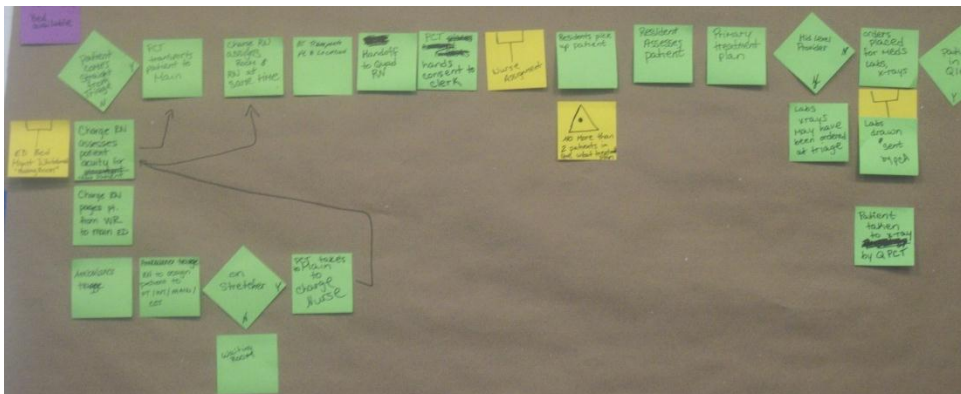
- Hot Mess- location of patients
- Confusion
- Lack of accountability
- No clarity in specific
- Too many cooks in the kitchen

# Box 3: Target State



- Nursing check-in, bed assignment and placement is conducted in a timely manner.
- Team approach to patient care with charge/head nurse rounding with team at every tour.
- There is standard work delineating a flow master and consistent adherence to said standard

Measure	Pre-Event	Target
Human Development Breakthrough Engagement	151 (as of 7/3)	+3
Timeliness/ Delivery Median Triage to Assignment (First Provider) from Control Charts	81 minutes (6 month median)	G: 70 minutes VG: 65 minutes O: 60 minutes
Timeliness/ Delivery Median Assignment to Disposition in Main	3:54 (h:mm) 6 months	G: 3:20 (h:mm) VG: 3:15 (h:mm) O: 3:10 (h:mm)

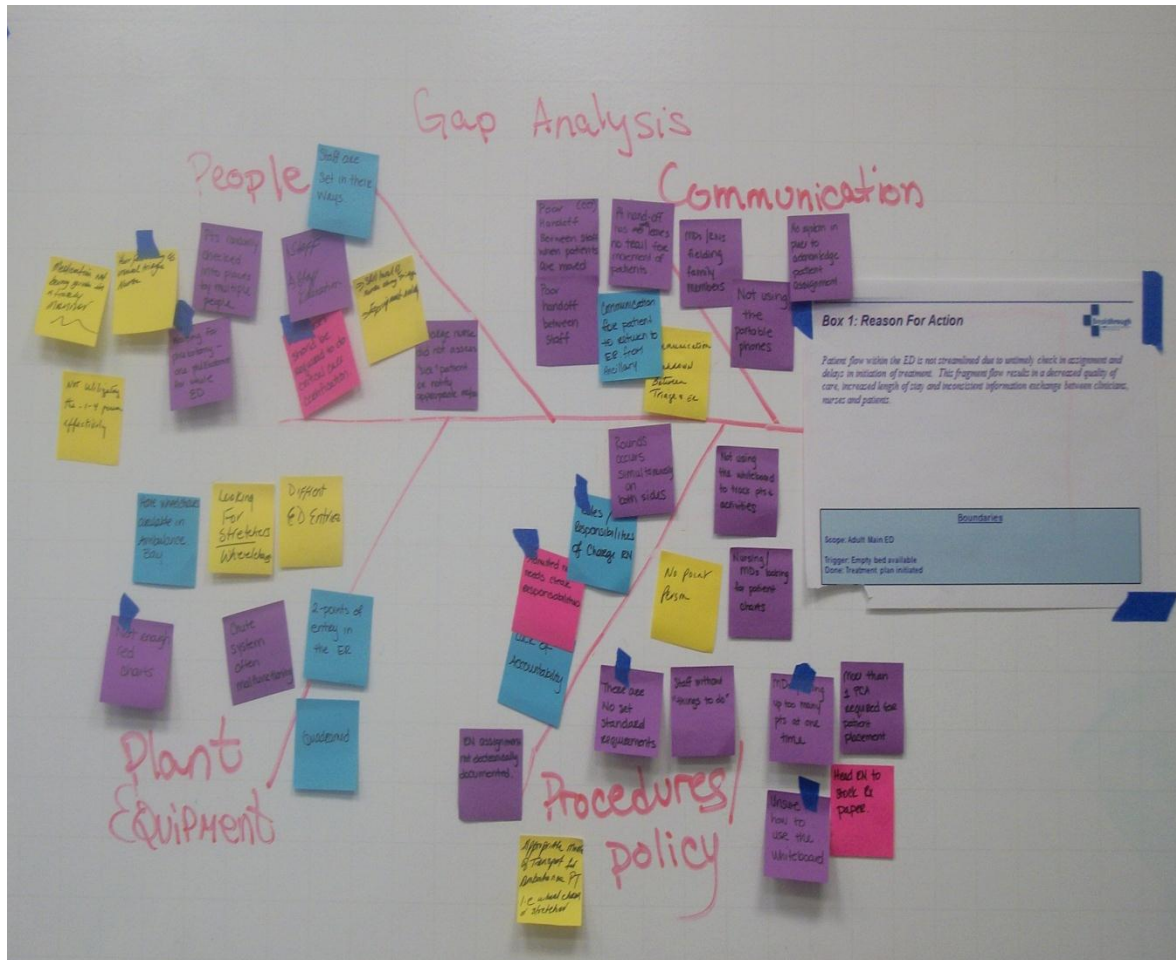


## Target State Attributes

- Organized
- Streamlined
- Situational awareness
- Fluidity
- Accountability
- One person in charge of placement
- Adequate communication by staff



# Box 4: Gap Analysis



- We brainstormed as a group to identify all gaps
- We then categorized the gaps and used a fishbone diagram to drill down to the root cause and of the problems
- Major gaps:
  - Ineffective patient tracking
  - ED Whiteboard knowledge
  - Varied skill level of staff

## Box 5: Solution Approach



Potential Root cause:	If We:	Then We:	Metric
Lack of clarity about who is responsible to complete specific tasks	Create standard role & responsibilities for key players	Know who is accountable to complete each task	Median Triage to Assignment
Staff lack of knowledge regarding use of white-board	Re-inservice staff on white-board tools	Will have a clear understanding on how to use the whiteboard to manage flow	Median Assignment to Disposition
Incorrect bed/location assignment	Assign one person to be in charge of patient check-in	Decrease time spent searching for patients and delays in check-in and assignment	Median Triage to Assignment
Poor hand-off	Create a system that allows for RN-RN hand-off for all new assignments	Will improve communication to decrease delays in treatment	Median Assignment to Disposition
MD's see patients in batches	Eliminate batching and create 1 by 1 flow	Decrease the amount of time that patients wait before they see their doctor and receive treatment	Median Assignment to Disposition
Varied skill levels	Standardize the skillset required to work in the ED	Enhance the level of care for our patients	Median Triage to Assignment

## Box 6: Rapid Experiments



Experiment	Expected Outcome	Actual Outcome	Follow up
Charge nurse simultaneous RN and bed assignment based on acuity	Decrease time from charge nurse assessment to placement	12 patients placed in an average of 2 minutes	Implement
Clerk responsible for consent and chart	Zero charts lost	0/12 charts lost	Implement
Charge/Head/Quad nurse included in ED resident rounds	Faster implementation of treatment plan	2 quads with bidirectional communication between MD's and RN's	Implement
Resident 1:1 flow with standard WIP	Faster implementation of treatment plan	Fewer delays in presentation to attending	Implement
Division of nursing responsibilities between ED patients and medication administration for admitted patients	Faster nursing assessments and execution of orders for ED patients	2 implementations 1 during day shift, 1 during evening shift. Data to be gathered and reported	Implement



# Box 7: Completion Plan



RIE	Project	JDI	What	Who	When
X			Develop A3 to determine and quantify benefit of RN assignment to medication administration for admitted patients	Josepha Miranda, RN	9/6/13 RIE scheduled for Jan2014
		X	Explore feasibility of modifying whiteboard to track completion of Quad RN nursing assessment	Josepha Miranda, RN	9/6/13
		X	In-service all staff on standard work (MD's, nursing, clerical)	Marie-Laure Romney, MD Josepha Miranda, RN Otis Freeman	9/13/13
		X	De-activate hard stop in Quadramed for triage note completion with regard to check-in assignment	Eddie Antoine	9/16/13
		X	In-service staff on use of whiteboard	Marie-Laure Romney, MD Josepha Miranda, RN	9/13/13
	X		Develop training calendar for ED certification and skill-building (add to VSA box 7)	Josepha Miranda, RN	9/13/13

# RIE 37: Treatment Flow August 2013

## Box 8: Confirmed State at September 1, 2014



True North	Metric	Baseline	Target	Confirmed State RIE week 8/23/2013	Status				
					Sept 30d	Oct 60d	Nov 90d	April 2014	August 2014
Human Development	Breakthrough Engagement ED staff 1st time on RIE team	151 (as of 7/3)	+3	+5	156	156	156		
Timeliness/Delivery	Median Triage to Assignment (First Provider)	81 mins (6 month median)	G: 70 VG: 65 O: 60 mins	71 mins (low census in ED)	82	61	66	56	63
Watch Metric:									
Timeliness/Delivery	Median Assignment to Disposition in Main	3:54 (h:mm) (6 month median)	G: 3:20 (h:mm) VG: 3:15 (h:mm) O: 3:10 (h:mm)	1:53 (h:mm) (low census in ED)	3:45	3:38	3:27	3:26	3:25

# Box 9: Insights



What Went Well	What Could Improve
<ul style="list-style-type: none"><li>• A better understanding of ED process</li><li>• Hearing the opinions of people from different roles</li><li>• Everyone added something</li><li>• Gemba walk</li><li>• We all agreed on the plan that was executed</li></ul>	<ul style="list-style-type: none"><li>• Hit on a lot of things that were out of scope</li></ul>
What Helped	What Hindered
<ul style="list-style-type: none"><li>• Cleaned up some misconceptions of the ED flow</li><li>• Seeing the staff/patients in action</li><li>• Identified multiple gaps in patient flow</li><li>• Running experiment helped confirm Target state</li><li>• Having Nursing Leadership around</li></ul>	<ul style="list-style-type: none"><li>• Digressions</li><li>• Re-assessment of scope</li><li>• Many problems to be addressed globally</li><li>• Talking over each other</li></ul>

What did we Learn
<ul style="list-style-type: none"><li>• If simple direction is given, staff will have clear understanding of their responsibilities.</li><li>• The difference in duties PCA/PCT &amp; Head Nurse vs. Charge Nurse</li><li>• How batching effects efficiency</li><li>• There is no evidence of standard skill set requirements to work in the ED</li></ul>

## ***Impact –***

***What's going to be different for our patients and families..***



- ***Less time spent looking for charts***
- ***Less wait time before nursing assessments***
- ***Faster response to changes in medical condition***
- ***Fewer delays in medication administration***
- ***Smoother-running process with fewer bottlenecks***
- ***Greater emphasis on the usage of the whiteboard***
- ***Improved tracking of patient flow through treatment***
- ***Happier patients and staff!!!***