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md CONNECT

A Newsletter for Huntington Hospital Physicians

Huntington Hospital

Spring 2009

IMPROVING PRODUCTIVITY

Having a productive workforce is the goal of most organizations, and Huntington Memorial Hospital is no different. Three years ago we began laying the groundwork for labor benchmarking when we created a system to monitor hours worked per unit of service. As a result, bi-weekly productivity reports are distributed to department managers and are used as a tool to manage labor or volume.

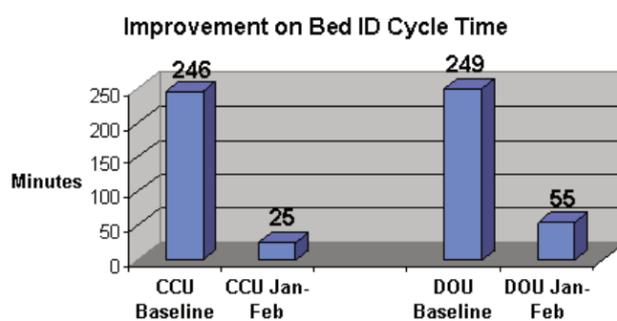
Last year we took this process a step further and began comparing our internal benchmarking to other California hospitals our size. Every department's data was collected, analyzed and compared to determine where we have an opportunity for

(continued on next page)

Capacity and Throughput Initiatives

Your feedback from the physician satisfaction survey identified bed capacity as the main barrier preventing physicians from admitting patients to our hospital. We launched several Six Sigma projects focusing on capacity and throughput. The goal of these projects is to ensure that we have the right bed, for the right patient, at the right time, but more importantly, to improve quality through operations, and strengthen physician relations.

We first deployed a detailed data analysis concluding a strong correlation between ICU/DOU capacity and the overall capacity. In other words, ICU/DOU beds were a bottleneck in moving patients through the hospital. We dedicated a project focusing on ICU/DOU throughput. According to our baseline data, the average time it took to identify an ICU bed for a patient was 246 minutes.



(continued on next page)

In our last issue of MD Connect we introduced our Six Sigma project on the cost management of implants in spine surgery. Working together with our surgeons, we have made significant progress in cost reduction by setting a pricing format for select products. All vendors were invited to participate through adoption of the new pricing format; however some chose not to participate. This project was implemented in February and we anticipate a \$1 million cost reduction in 2009.

The current phase of the project is reviewing biologics. Data shows that when a surgeon takes part of a patient's hip bone to use in spinal fusion surgery, it adds to length of stay and leads to more pain for the patient. An alternative is purchasing different kinds of artificial bones that will improve the patient experience as well as our length of stay issues. Our next step is to bring these items and their cost data to the respective orthopedic and neurosurgery committees and together create an improvement plan.

According to SG2, a healthcare intelligence company, "the cost of hardware and new technology continues to put strain on the financial viability of spine programs. Significant payment changes are likely within the next couple years." Hospital administrators are aware of the escalating cost of implants, and now it is becoming an industry-wide initiative to lower costs.

In our next issue of
MD Connect:

- OR turnover time
- Quality Reporting

Improving Productivity (continued from page 1)

improvement. Currently, our department leaders are reviewing that data, having discussions with leaders at the hospitals against which we were compared, and taking that knowledge to create plans for greater efficiency.

This initiative is not a result of the country's current economic crisis. It began in 2006 and is a philosophy we are committed to for years to come. However, the financial losses we face as a result of the crisis underscore the importance of this project in order to secure a strong future for Huntington Hospital. As our departments unveil their plans, processes may change, so we thank you in advance for your patience as we adapt to a more efficient workplace.

Capacity and throughput Initiatives (continued from page 1)

We implemented a standardized level of care system to assist in communicating patient condition. The red, yellow, green coding system indicates if a patient should stay in ICU (red), is available for discharge within 24 hours (yellow) or is ready to move to another unit (green). Additionally, we looked at operational process improvement to facilitate transfer of patient and room readiness (cleaning process) once a patient transfer has been activated.

Following the launch of this project, we have observed a 90% reduction in the bed identification time with a new average of 25 minutes. We have also observed a similar improvement in the DOU; a 78% reduction in the average bed identification time bringing the current time down to 54 minutes.

By identifying available beds sooner, we can admit patients faster and reduce the time a patient has to wait for a bed. Our goal is to continue to progress as well as identify additional opportunities for improvement. We will apply what we learned from the ICU and DOU to other units to promote overall efficiency.

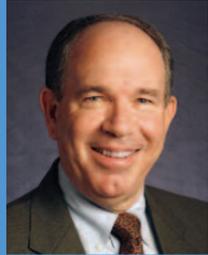
Another component of the capacity and throughput projects is to promote a safe and efficient discharge for patients. The first step to ensure a smooth process is to obtain a complete discharge order. Studies have shown that discharge orders written earlier in the day contribute to promoting a more efficient discharge process. Our data from the physician

discharge Six Sigma project shows that 68% of our discharge orders are written after 12pm. To get a better understanding of the barriers and how to improve the process, we reached out to you to obtain your feedback. Based upon your response, we have identified several improvement strategies. We will apply these strategies to a medicine unit in order to obtain better control and measurement of the outcome. If they are successful we will expand them to other units in the hospital. When physicians are rounding before noon, we are doing the following to streamline the discharge process:

- Streamline workspace for physicians and standardize chart location
- Improve timeliness of diagnostic testing and availability of results
- Create educational materials for order requirements to ensure they meet standards

In addition to the above, we are creating visual management tools to facilitate communication (staff receiving physician order in timely manner). We are still working on improving the process of facilitating a safe and efficient discharge as well as promoting an earlier discharge start time.

A strong physician relationship is the key to success, so please inform your colleagues about the quality initiatives around capacity and throughput. Collaboration will ensure results that are sustainable. Look for further updates in upcoming issues of *MD Connect*.



General Staff Meeting

Tuesday, June 9 12:00-2:00 p.m. Lunch will be served.

Featuring CEO Steve Ralph, Jim Noble, CFO to discuss:

- State of the hospital, financial and otherwise
- Possible reimbursement changes on the horizon for hospitals and physicians
- Open discussion to address questions and concerns

Invitation coming soon by email, snail mail and fax.

Healthcare Information Technology (HIT) and the Economic Stimulus Package

FOR SEVERAL YEARS, HIT has been a topic of much discussion in Washington, DC. But prior to 2009, it had been the subject of infrequent action and inconsequential funding. Certainly, there have been HIPAA privacy and security provisions, quality data submission requirements and the encouragement of electronic data exchange. Electronic partnerships between hospitals and referring physicians were essentially restricted (Stark regulations) and subsequently relaxed. 2008, though, saw a notable increase in the visibility of HIT, resulting from two major drivers: 1) e-prescribing was encouraged through "carrot-and-stick" Medicare funding, beginning with a 2% incentive in 2009; and 2) the Obama presidential campaign promoted investing \$50 billion in HIT over 5 years.

It is April as I write this, but 2009 has already seen a dizzying leap forward in the prominence of HIT at the federal level. On February 17th, President Obama signed into law the \$787 billion American Recovery and Reinvestment Act of 2009 (ARRA, colloquially known as the Stimulus bill). Notable among its many provisions were \$2 billion for HIT infrastructure standards and \$17 billion for EHR/EMR (Electronic Health/Medical Record) incentives. I'll focus on the EHR incentives for most of this article, but let's first review some other ARRA elements.

ARRA cites the following goals: having 90% of physicians, and 70% of hospitals on electronic records by 2019. ARRA covers many HIT topics, including:

- It expands federal privacy and security laws, strengthening HIPAA.
- It promulgates HIT standards, certification and best practices.
- It provides funding and sets direction to further nationwide electronic data exchange and care coordination.
- It funds the deployment of broadband communications in under-served areas, with the intent of enabling data exchange and telemedicine.

I'll shift now to the largest funding element, which is the \$17 billion of Medicare and Medicaid (better known as Medi-Cal here in California) EHR incentives. Broadly, the federal government is once again adopting a carrot-and-stick approach.

Eligible physicians will qualify for Medicare or Medicaid incentive payouts, if they demonstrate "meaningful use" of a "certified" EHR:

- The maximum Medicare incentive is \$44,000 per physician over five years.
- The maximum Medicaid incentive is \$64,000 over five years, per physician. It is EHR-cost-based and only available to independent physicians with at least 30% of their cases attributable to Medicaid; for pediatricians, the threshold is 20%.
- Incentive payouts become available in 2011, but the maximum incentive decreases if the physician starts after 2012. Medicare payment penalties for non-adoption start in 2015.
- While meaningful use is not fully defined, it is expected to encompass e-prescribing, electronic information exchange and quality measure reporting.
- It is generally believed that the Certification Commission for Healthcare Information technology (CCHIT.org) will be the body that addresses the certification issue.

Huntington Memorial will qualify for similar federal incentives in 2011, based on its own meaningful use of certified EHR systems on behalf of its Medicare and Medi-Cal patients. Please do note that much of the information about ARRA and the EHR incentives remains preliminary and subject to executive branch interpretation. Hospital leadership will continue to monitor developments and advise you as we progress on these important initiatives.

Scott Cebula
VP, Chief Information Officer
April, 2009

DID YOU KNOW...

that the following services are moving to the Huntington Pavilion this spring?

- Huntington Hospital Cancer Center
- Huntington-Hill Breast Center (formerly Hill Breast Center)
- Vascular Lab
- Neurosciences
- Pre-op testing
- Huntington-Hill Imaging Center (formerly HOPIC)

Huntington Hospital is looking for physicians interested in participating in a leadership development program. If you would like information about the program which includes education and coaching to assist physicians with current and future hospital leadership roles please contact Bernadette Merlino at (626) 397-5555 or email her at Bernadette.merlino@huntingtonhospital.com.