FAST FACTS

High Quality
Patient Centered
Cost-Effective Health Care

From Dr. Katz

## A Message From the Director

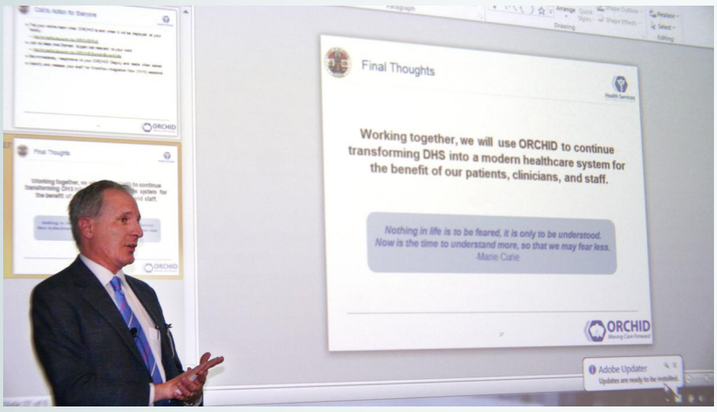
Ever since I became Director three years ago, I have wondered, how we can better communicate across our department? Ideally, the communication would be face-to-face, but how can you do that when you have 18,000 employees and leagues of contractors working round the clock in dozens of facilities stretching from High Desert to Long Beach? Clearly we won't all fit in an auditorium, and even if we could rent out Dodger Stadium, imagine the traffic it would cause and the loss in time taking care of our patients.

What I have been wondering is whether there is a way to use modern communication to bring us closer together.

This Monday, February 24, we will try a Virtual Town Hall. We will simultaneously come together in our different facilities. We will talk about the successes we have had these past three years in preparing for health reform and the challenges ahead of us.

This is our first one, so it may not be perfect, but we will have monitors at 15 facilities. I will be speaking from LAC+USC. There will be an opportunity to ask questions and make suggestions from your facility, and we will tape it so that it can be seen by people on other work shifts. If it is a success, we will expand it to include our Community Partners.

Look for email announcements with more details. I hope to "see" you there.




# ORCHID Coming to a Facility Near You

By Michael Wilson

DHS clinical and administrative leaders attended a briefing on the ORCHID implementation last month. Harbor-UCLA Medical Center and affiliated health centers will be first to go live with the new electronic medical record system this summer, with other hospital and clinic sites rolling out through early 2016.

"Is there anything else that better connects all of DHS as one entity?" asked DHS director Mitchell Katz, MD. "Ultimately our future is ORCHID, it has to be the thing that matters the most for us to succeed."

With the nuts-and-bolts build work now 50% complete, DHS is moving closer to realizing the enterprise system that will replace Affinity and transform care delivery. Providers will gain a 360-degree view of a patient's medical history, nurses will be able to chart more rapidly, and quality experts will be able to mine performance data electronically.

Hospital and Ambulatory Care Network chief executives were reminded of their executive sponsorship roles to drive project success at every facility. They were asked to marshal all necessary resources, including appointing a deputy to coordinate all ORCHID-related activities.

About 900 employees are now working with a large Cerner team to tailor the system to DHS. Subject matter experts and IT analysts from nursing and clinical documentation, emergency medicine, pharmacy, lab, surgery, and 20 other workgroups are creating system specifications with help from chief medical information officers, domain experts, and project managers.

Despite technical progress, ORCHID leaders said there are still many factors that could derail the project, such as employee reluctance to adapt to the new technology, outdated policies and procedures, and lax education. As with any new technology, there will be issues that cannot be anticipated but must be managed when they happen.

"ORCHID is pushing the need for us to perform as managers to a much higher place," said DHS chief medical officer Hal Yee, MD. "It is almost certain that you must have a management strategy in place to promptly move resources around based on clinical needs because there will be things you never thought of before that will require rapid response."

ORCHID stands for Online Real-Time Health Information Database, and is a major component of the IT clinical care improvement portfolio, including the e-Consult specialty referral system and the i2i disease registry. Regular updates on the ORCHID project can be found on the intranet at http://myladhs.lacounty.gov/collaboration/epmo/Projects/ORCHID/SitePages/Home.aspx or by emailing the ORCHID team directly, ORCHID@dhs.lacounty.gov.

# DHS Readies for ICD-10


Medical coders and providers in DHS hospitals and clinics are preparing to shift to the new ICD-10 code set this year, which replaces the 30 year-old ICD-9 system. All U.S. hospitals and outpatient facilities are required to use the new system on October 1, 2014. The new code set permits the tracking of many new diagnoses and can be expanded to over 16,000 more codes by using optional sub-classifications.

ICD stands for the International Classification of Diseases and standardizes the way coders record illnesses and procedures for statistics and reimbursement by government programs and private payers.

Some 25 countries use ICD-10 for reimbursement and resource allocation in their health systems. These 25 countries made modifications to ICD to better accommodate diseases that are unique to their countries, and the system allows for this flexibility; for example, the U.S. will use a clinically modified ICD-10 (ICD-10CM) which has some 68,000 codes. The U.S. also will use ICD-10 PCS, a procedure code system, not used by other countries, that contains an additional 76,000 codes. The unchanged international version of ICD-10 is used in about 110 countries.

Health Information Management

(See '**ICD-10**' on back)

## Hospital Hand-Hygiene Effort Leaves People Foaming

By Michael Wilson

Late last year Olive View-UCLA Medical Center kicked off an intensive campaign to get staff to "Foam In/Foam Out" and observe the World Health Organization's "5 Moments of Hand Hygiene": before patient contact, before aseptic tasks, after body fluid exposure risk, after patient contact, and after contact with patient surroundings.

The initial focus of the Foam In/Foam Out campaign has been in the Intensive Care Unit (ICU), where a 90 percent compliance rate has been achieved. Based on observations by outside monitors, baseline compliance in December was 74 percent. After the initial interventions, audited compliance in January and February increased to over 90 percent among all staff working in the ICU.

All hospital staff were required to watch a video on hand hygiene that starred clinical leaders from across the hospital and taught proper hand hygiene techniques and then take a post-test, says hospital Patient Safety Officer Sue Stein, MD. A team of hand hygiene "coaches," made up of staff from Quality Services and Nursing, spent time in the ICU observing and educating staff if they failed to properly clean their hands before or after patient contact. The project focuses on non-punitive activities, such as the use of a foam hand and staff-to-staff communication to improve hand hygiene compliance.

To emphasize the organization's commitment to this initiative, guest coaches, including the Physician Director of the ICU, Patient Safety Officer, Infection Control Physician Director, Compliance Officer, Chief Medical Officer, and managers for Environmental Services Manager, Rehabilitation Services, and Respiratory Therapy, spent time on the unit observing and reminding staff of the importance of proper hand washing.

After the initial coaching phase, auditors handed out "tickets" to staff who missed hand washing opportunities. Staff who get more than three tickets will be sent to "hand-washing school" and required to review a presentation on hand hygiene and take a post-test. To date, due to strong staff participation, only one ticket has been given out.

Stein says an important lesson that has come out of the project is the importance of working with line staff, who educated the hand hygiene team members about their workflow. Working together, staff identified new ways to integrate hand hygiene into daily patient care activities and improve compliance.

The initial phase of this program has been extremely successful and staff engagement and participation has been high. The project is now being rolled out to other areas of the hospital. "Hand Hygiene Champions" have been identified throughout the hospital and will be responsible for providing real-time coaching to staff and provide feedback to those who are not in compliance with the hand hygiene requirement, and issue tickets for continued non-compliance.

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('**ICD-10**')

(HIM) coders will have to relearn this new coding classification to be ready by October 1, 2014 discharges. Due to the complexities of ICD-10 CM (Diagnostic) and ICD-10 PCS (Procedural) coding, DHS coders began classes on anatomy, physiology and pathology in October, 2012, because the new system requires a much higher level of understanding when reviewing the medical record.

"The most important change with ICD-10 is that our coders must be trained to a much higher level," says DHS Enterprise Health Information Management Director Harvey Jones, who is leading the training and developing a new coding quality division.

The DHS transition will go smoothly, but there may be a drop in productivity of physicians and coders because of the more specific documentation required by the new system. Taking a view of the transition of the last country to go live with ICD-10, Canada's coders experienced a 47% decrease in output for nine months and recovered to approximately 10 to 15% less output than before ICD-10. As each medical facility in the U.S. prepares for this decline, coders are becoming less available in the market place.

Jones said training is also being developed for physicians to learn about the changes of ICD-10 and clinical documentation expectations. Dr. Brad Spellberg of Harbor-UCLA Medical Center will serve as the Physician Champion for the ICD-10 documentation improvement for all of DHS health facilities. There are also Physician Champions identified at each medical facility for the success of this national mandate.

## New Guidelines Aim to Prevent Stroke in Women

By Michael Wilson

Women with preeclampsia (pregnancy related hypertension) have twice the risk of stroke according to first-ever guidelines published this month that shed new light on the role hormones, pregnancy and childbirth play in stroke risk. The guidelines were developed by the American Heart Association and appear in the current issue of the journal *Stroke*.

Rancho's Amytis Towfighi, MD

High blood pressure, smoking, and high cholesterol are well known stroke risk factors in men and women. Other risk factors like migraine with aura, atrial fibrillation, obesity, diabetes, depression and emotional stress are stroke risk factors that tend to be stronger or more common in women than in men. In addition, women have unique stroke risk factors such as hormonal contraception, pregnancy, and hormone replacement therapy.

Chances of a stroke increase with age, but the obesity epidemic and higher rates of diabetes means young people are increasingly susceptible. Worldwide, stroke is the second-leading cause of death after heart disease and is also a big contributor to disability.

Rancho Los Amigos National Rehabilitation Center neurologist and associate medical director Amytis Towfighi, MD, a co-author of the guidelines and national stroke expert, says the guidelines are intended to help primary care providers and obstetricians/gynecologists as a tool to aid prevention.

"Each year, more women than men have a stroke. Stroke has declined to the fifth leading cause of death for men but remains the third leading cause of death for women in the United States. In addition, compared to men, women tend to have more severe strokes, are more likely to be disabled after stroke, and are more likely to be institutionalized after their stroke" said Towfighi. "Given the tremendous burden of cerebrovascular disease among women, women and their doctors need to be aware about risk and start a dialogue to prevent a stroke. The gains that have been made in recent years in reducing smoking rates and improving blood pressure control have been offset by the obesity epidemic which disproportionately affects women in the United States; therefore, interventions to improve diet and physical activity habits early in life are likely to help mitigate stroke risk."

Among the guideline recommendations are that women with a history of hypertension before pregnancy be considered for low-dose aspirin and/or calcium supplement therapy to lower preeclampsia risk. Pregnant women with moderate high blood pressure may be considered for hypertension medication and expectant mothers with high blood pressure should be treated. Women should also be screened for high blood pressure before being prescribed hormonal contraception because medications for contraception can raise blood pressure in some women.

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