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Patient-focused care boosts patient satisfaction while enhancing safety

Wide variety of technology brings care directly to the patient

From testing to telemetry, patient care is being brought to the bedside of a growing number of patients across the country. Engendered by constantly evolving and improving technology, patient-focused care is demonstrating a significant potential for improving patient safety while bolstering satisfaction.

"Rather than having the patient go through the pain and suffering of being moved around, we now bring the treatment or testing to them through patient-focused care," says **Patrice L. Spath**, a consultant with Brown-Spath & Associates in Forest Grove, OR. "They become the center of the wheel."

The centerpiece of patient-focused care is a growing array of services known as point-of-care (POC) services. Among these is POC testing. "In general, [POC] has a number of advantages," says **James Nichols**, PhD, associate professor of pathology at Tufts University School of Medicine in Boston, and medical director of clinical chemistry for Baystate Health System in Springfield, MA, where he supervises POC testing. "It requires a smaller amount of blood and is minimally invasive, which is very useful for neonates, who do not have much blood. And you can do the test right there and go on with the treatment, which maintains continuity of care."

Marc T. Zubrow, MD, director of critical care for Christiana Care Health System in Newark, DE, says he is reaping benefits in both patient safety and satisfaction from his recently installed Flexible Monitoring system (manufactured by Welch Allyn Inc. based in Skaneateles Falls, NY), which uses wireless telemetry to

Key Points

- Bringing treatment to patients lessens their pain and suffering.
- Services delivered at point of care include monitoring and testing.
- New technology helps avoid handoffs of patients and information.

monitor patient heart rhythms.

"Patients can literally go anywhere, and people will know what's going on [with them]; and they can be easily found in case of emergency," he notes. "Also, I had observed that in regular step-down units, the monitor watchers really weren't watching; nurses had many other duties and were often called away. Plus, the cacophony of alarms in traditional step-down units is disturbing, especially when a patient is trying to sleep."

Spath agrees that patient-focused care can enhance patient safety. "There's a significant patient safety aspect, in that any time a patient is handed off from one caregiver to another, there is a chance for an event,. Not only does the patient have to be handed off, but information relevant to that patient has to be handed off as well."

In addition, POC enhances patient safety through improved identification technology, she adds. "If you are right at the bedside and get a drop of blood to test, you don't have to worry about the vial being mislabeled, getting mixed up, and having the wrong report coming back," Spath notes. "It definitely does minimize the patient ID problem."

The number of applications for POC services is nearly as wide as the applications a health care professional can envision. In testing alone, for example, it can include:

- blood gases
- electrolytes
- Ca++
- Na+
- K
- Mg++
- hematocrit
- glucose
- creatinine
- blood urea nitrogen

"There is an advantage to performing the top 10 most popular tests at the patient bedside since it is expensive to package, transport, unpackage, relabel, and rack the specimens for analysis. Furthermore, bottlenecks are created in the central laboratory when large numbers of specimens queue up for labeling, aliquoting, and centrifugation,"[1] wrote **Robin A. Felder**, PhD, of the University of Virginia, Charlottesville.

Christiana already is contemplating the expansion of its monitoring program beyond cardiovascular data. For example, implementation of wireless multiparameter monitoring, including noninvasive blood pressure and SpO^2 (blood oxygen saturation) are being considered.

Radiology is another area where POC applications are numerous, including picture archiving and communications systems; medical imaging displays and display controllers; and POC workstations. Interventional radiology, fluoroscopy, digitized X-rays, and ultrasound are just a few of the specific areas of application.

Primarily, the major benefit [of POC radiology] is having images directly at the patient's bedside for referral or consultation," says **David Hebert**, marketing manager in the medical business unit for Planar Systems of Beaverton, OR, a major manufacturer of flat display panels and other POC products.

"Under the old model, you had to print the exam results in radiology, then walk over to the patient's bedside and then use it in conjunction with whatever procedure was planned. This

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Editorial Questions

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affords a tremendous time savings."

Planar produces a wide range of diagnostic or referral quality displays for radiology, including the recently introduced Invitium POC workstation. This involves either a "normal" CPU or a thin-client CPU that actually is embedded into the display panel on a card, so it is mobile and available to any clinical informatic.

What is the future of POC radiology? "In an ideal world, as we advance, we will be integratable into CPOE [computerized physician order entry], drug administration programs — ideally, any and all patient data that can be accessed at the bedside," Hebert says. "This will allow the opportunity for increases in quality of care, but distributing critical information as widely and as quickly as possible."

Zubrow initiated his project in response to the constant challenge of finding enough step-down beds for patients coming out of intensive care. "I noted that most patients being observed in the step-down environment could be monitored from a remote site, and in that way, multiple areas of a hospital could all be monitored from the same site," he recalls. "The same thing is true in upgrading; if a patient requires monitoring, you can do that remotely rather than having the domino of bed transfers to make beds available."

The system being used by Christiana, which was developed by Welch Allyn, "is a superior system," Zubrow says. "It was the first on the market that had a screening ion, which enabled us to visualize the patient's heart rhythm on their body." In other systems, he explains, when a patient has an acute problem, the health care professional usually has to push a button to get more specific information. "With this system, you walk in, and if you think you hear something you're not used to hearing in the rhythm, you have instant information."

Patients who are being monitored have leads on their bodies, which send information to a small box that also is on their person. The box, in turn, sends information to an antenna on the ceiling, which then sends the data through a land line to the monitoring room, staffed by monitor technicians, who are responsible for arrhythmia detection of all patients being monitored by the system.

"Before, we had to move patients to specific [hard-wired] rooms," Zubrow says. "This also meant a new set of nurses. This was a huge patient dissatisfaction issue." At the same time, Christiana implemented a STAT (stabilization-transport-administration-teaching) nurse program to support the changes of added monitoring to multiple nursing units. The STAT nurse is a medical intensive care nurse available 24/7 to help provide critical care for patients. "The STAT nurse responds to changing status," he explains. "If a patient's condition changes, there is immediate response."

There are two hospitals in the Christiana system. At Christiana, where the system has been in use since 2001, there are three central stations in use, each monitoring 44 patients. At Wilmington, there are four such stations.

"I think this has been a huge advance; I believe we are on the cutting edge, and the rest of the country will be doing this in short order," he says. "We've had a number of wonderful resuscitated patients who might not have been found that easily. Our survival rate for cardiac arrest is just as good [as for patients monitored in the more traditional fashion]. One of the concerns had been that we would not find these patients in time, but our data on in-hospital codes show we're doing every bit as well as step-down patients. This is a safety net we *know* is saving lives."

This is just the beginning for Christiana when it comes to remote monitoring, Zubrow says. "Pretty soon, we will be monitoring 'pulse-ox' [pulse oximetry] — perhaps within the next six months — and we will also be doing noninvasive monitoring of vital signs," he says. "Now, for example, if a patient on the floor requires medications through an intravenous drip, the pharmacy rules require they be in a certain location. In the future, we may not have to move the patient; this will improve patient care without increasing the need for personnel. In view of the current nursing shortage, this improvement in nurse productivity is very important."

Many testing applications

As director of all clinical chemistry and, therefore, responsible for POC testing, Nichols has numerous opportunities to employ such technology in the three-hospital Baystate system, which includes some 40 outpatient clinics, several nursing homes, and a Visiting Nurse Association. A number of simple tests are performed regularly, including urine dip strips, glucose, occult blood, pH, pregnancy, rapid "strep" tests, blood gases, electrolytes, and creatinine at POC. "A sample is taken, usually by finger stick or via the urine, then put onto either a dip strip or onto a kit," he adds.

There is a computer inside the hand-held

device. Before the test is performed, the operator is asked for the patient's ID number. "This way, the computer knows the patient and the lot number and links them to the result," Nichols explains. "Then we put the device into a docking station linked to our intranet, and it automatically sends it to our lab information system, then refers it back to the patient care system."

The time savings are significant; the whole blood does not have to be processed, spun, and separated. "You just put the whole blood on the device — it's faster; you don't have to draw it, wait for it to clot, spin it in the centrifuge, and then get the result to the clinician," he says.

Other applications for POC testing include infectious diseases. "We've had some requests for HIV testing," says Nichols. "We also do coagulation, prothrombin time, coumadin levels, and ACT testing in cardiac cath areas."

Nichols sees several advantages to POC testing. Moving these tests to the bedside improves patient satisfaction and makes the care more patient-focused, he says. "I think it's more convenient. It brings analysis to the bedside, where the physician is as well, so it all works within the flow of patient care." This is not to say that the impact is totally positive, however. For example, staff sometimes can complain about the additional responsibility. "There is a general feeling that nursing is being dumped on, but we are all doing more," Nichols explains. "It's narrow-minded to not think of this as part of patient care — as much as taking a temperature, weighing the patient, taking vital signs, or giving drugs."

Still, there can be drawbacks to POC testing, he says. "You take lab testing, which is a well-defined, structured process. With point-of-care testing, you are outside of an environment you can control. That leads to problems. In a lab, you have controlled temperature and highly trained people whose sole function is to analyze specimens. They are just focused on turning out results. If you take this outside the lab, you can start to get errors and problems."

For Nichols, the issue of whether to use POC is not cut and dried; rather, it is a question of weighing pros and cons. "You really have to balance everything," he advises. "In the patient care setting, is this effective and is it going to lead to a better outcome? Does the work of keeping quality up outweigh the benefit of the increase in quality? What am I doing for that patient, and am I doing it frequently enough? Do I have well-trained people who do this on a daily basis so I can trust the results?"

If the results you get are "just numbers," Nichols explains, that can be dangerous. "Make sure you pick devices that have foolproof checks and balances, so you get a number that is meaningful. Plus, a lot of what you do is manual, so the documentation is not always there. Without a computerized system in all POC devices, we lose much of its potential."

Spath agrees. "It *has* to be tied into your information system; otherwise, the nurse has to write it down." There are challenges involved in hooking into the rest of the electronic information system. A lot of labs are electronic, she says. "But if all you have is a hand-held pulse ox, it never becomes [part of the electronic] record."

Assuming you determine the benefits will outweigh any potential problems, just how difficult is it to do, for example, what Christiana did?

"There is a substantial financial outlay on the front end," Zubrow concedes. "But you can cost justify it if you extrapolate the cost of a nurse reader vs. a monitor reader, then the cost of transferring a patient — say, $200 or so. And who can put a cost on the reduced medical legal risk?"

In the final analysis, Nichols appears to agree. "In many instances, I see this as a wonderful technology for patient care and for improving what we do," he says.

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Reference

1. Feder RA. "The Distributed Laboratory: Point-of-Care Services With Core Laboratory Management." In: Price CP, Hicks J, eds. *Point of Care Testing,* Washington, DC: The American Association for Clinical Chemistry; 1999. ■

Checkoffs play key role in SICU improvement

Checklist helps team follow care plan

A patient daily goals checkoff form used twice daily during rounds has helped the surgical intensive care unit (SICU) team at Hartford (CT) Hospital achieve a 25% drop in its mortality rate, while cutting lengths of stay and ventilator days.

The 800-bed hospital, a level one trauma center and urban teaching/tertiary care facility, is a major affiliate of the University of Connecticut School of Medicine and one of the original participants in the "Transformation of the ICU," or TICU Project, sponsored by the Veterans Health Administration to help improve the organization and delivery of care to the ICU.

One of the outgrowths of the project was the concept of a goals form for rounds, first employed at Johns Hopkins in Baltimore under the direction of Peter Pronovost, MD.

"It seemed to work there, and they asked if other teams would try it; we took that challenge," recalls **Eric Dobkin**, MD, director of the 12-bed surgical ICU at Hartford.

The hospital actually formed two different teams in the surgical and medical ICUs and came up with two different goals forms.

"We [the SICU] clearly had outstanding outcomes, and I think the main reason for that was the way our form was structured," he says.

The form Hartford uses **(see checklist, p. 114)** differs not only from the original Pronovost model but from many others Dobkin has seen implemented — including some in his own facility. "The real key is that to some extent, the others miss the point," he asserts. "Their focus is to use this as a to-do list, and I'm sure that is very beneficial. However, we chose a different path."

One of the key elements of the TICU project, he notes, is improving patient safety. "We felt [with our form] we could improve quality *and* patient safety," Dobkin says. "That's why some of our questions are attributable to patient safety. They not only reflect the clinical concerns of the patient, but also their safety and psychosocial concerns."

But the key take-home message, he underscores, is that, "We decided to design not just a to-do list, but something modeled after an airplane takeoff checklist." That's why, he says, not only is every item on the list expressed in the form of a question, but each question is designed with a default answer of yes.

The decision on the questions themselves was, like the SICU team, multidisciplinary. The team includes nurses, a physician leader (Dobkin), respiratory therapist, social worker, and midlevel practitioners (nurse practitioner and physician assistant). "We have a multidisciplinary care philosophy in the SICU, and we primarily developed the form by mirroring the way we presented patients on rounds," Dobkin explains.

"We have rounds twice a day, and they had been more or less formalized verbal presentations of the patient, going in systems order — pulmonary, cardiovascular, neurological," he says. "Traditionally, this had been given from the head or from notes. Since we were multidisciplinary, this would include issues around the whole patient. We thought about this and formalized the areas we routinely discussed into questions [for the checkoff]."

Multiple versions of the form were used before the final version was selected. "We asked for input from our nursing staff, so they could incorporate questions they felt were important, too," Dobkin says. His team started with a small "test of change," using one or two patient rooms, then four, then half the unit.

"Each time, the form changed," he notes. The compilation of the questions in their final form was handled by the nurse practitioner, Denise Lawrence.

Key Points

- Unit sees 25% drop in mortality following implementation of new form.
- Checklist not a to-do list, but enumeration of clinical, safety goals.
- All members of the multidisciplinary team are involved in process.

Communications improved

Dobkin says that one of the additional benefits of this form has been the elimination of a problem he has seen in every ICU in which he has worked. "Every day on rounds, the residents present the patients the same way, by system," he says. "At the end, the resident inevitably says the plan for the day is 'ABC.' Yet, when you ask the nurses, they inevitably will say there is no plan. I

(Continued on page 115)

SICU Patient Daily Goals Sheet

Why is the Patient here?	No	Plan : Morning	Revisions: Afternoon	Night
Appropriate level of sedation?				
Appropriate level of pain control?				
HOB elevated 30 degrees?				
Weaning/extubation assessment performed?				
Current vent support needed RWP candidate?				
Tissue perfusion adequate?				
Arrythmias treated/controlled?				
Optimal BP control?				
Volume status appropriate?				
IV fluids appropriate?				
Adequate nutritional support?				
Bowels regular?				
PUD prophylaxis?				
Electrolytes WNL?				
Glucose controlled?				
H/H appropriate?				
Coags appropriate?				
DVT prophylaxis?				
Cultures checked?				
Wounds checked?				
Skin intact?				
Antibiotic appropriate?				
Lines/tubes necessary?				
Tests /procedures ordered?				
Tests read/reviewed?				
Δ meds PO, adjust dosing?				
Consults ordered/contacted?				
Patient mobilized, OT/PT/ST?				
Primary service/consults contacted, plan discussed?				
Team aware of end of life plan?				
Family feels informed?				
Cont. Care/ Soc. Serv involved?				

RN ____ MLP ____ MD ____ RN ____ MLP ____ MD ____ RN___MLP___MD___

Source: Hartford (CT) Hospital.

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don't know if this is a delivery issue or a reception issue; but since we implemented this, we have had total buy-in from the nursing staff."

Dobkin has the data to back up this assertion. At the outset of this program, nurses were provided with blank goals forms after rounds and were asked to write down the plan for their patients. "We found when we measured that the nurses truly did only know about 50% of the goals planned," he points out. "But after we instituted the [checkoff] procedure, they knew 98% to 100%. We have tested this for a year and a half, and it has been consistent."

While there is no baseline for the residents, the current data show that 98% to 100% of them also know their goals every day, Dobkin adds.

It also provides reinforcement for the nurses that this form helps them know the goals for the day, he says. "Nurses feel better organized about their day." And even though it is not the form's primary function, it also *does* function later on as a to-do list for the nurses.

"Plus, it is a communication form," Dobkin explains. "We print it on fluorescent yellow paper, and we put it in clear plastic sleeves on the breakaway door to the ICU, so everyone involved with the case can see it."

Finally, he says, it serves as a safety and quality "force multiplier."

Of course, it is the change in outcomes that is "truly impressive," Dobkin says. The SICU has decreased its mortality rate from about 11.4% to about 8.3% since the checklist began being used, he reports. "We also decreased [average] length of stay by 1½ days and ventilator days on by one day," he adds.

Scientifically, of course, it is impossible to attribute the entire change to the checklist. "However, we have had no change in patient population, no new technology implemented, nor have we been doing any other studies during this time," he asserts. Could other hospitals duplicate Hartford's results? "Yes and no," he says. "This is very low-tech, simple, and cheap to do. The high cost is the commitment by the staff, including physicians, to use it."

The checklist is done for every patient every morning, then revised in the afternoon. Then at night, the resident and the fellow make sure every goal is being followed. "What's necessary is the absolute devotion and leadership by clinical care physicians," Dobkin says. "How did we do it? We have a great team, and I had the support of the director of the section of surgical critical care and chief of surgery."

The nurse practitioner and the physician's assistant also played a crucial support role. "When I was not there, they reminded the others to adhere to the plan," he adds.

Even so, there was resistance in the beginning, both from nurses and physicians. However, notes Dobkin, "they persisted only until they saw the results." ■

Program distinguishes illness from disease

Medical students to 'walk in shoes' of patients

First- and second-year students at the University of Michigan Medical School in Ann Arbor will be getting an unusual look at the processes of disease and illness beginning this fall, when they visit patients in their homes to gain an understanding of how family, environment, culture, and lifestyle all play a part in an individual's health.

It is hoped that through these visits, the students will come to recognize the important distinction between disease and illness that is at the foundation of this innovative program.

"We want to get the students to understand the *experience* of illness," explains **Arno Kumagai**, MD, assistant professor in the department of internal medicine and medical director of the Family-Centered Experience. "There's a fundamental distinction between illness and disease," he notes.

Take a disease like diabetes, he offers. "The disease is an abnormality of how carbohydrates are

Key Points

- Student teams will pay eight home visits in two-year program.
- Topics will examine the impact of disease on patients and their family members.
- First-year med students form beliefs that will last their whole career.

broken down, and students study, for example, what [physical complications] that can lead to."

These principles of biomedical science basically represent what many physicians think they are treating when they treat a patient, Kumagai asserts. "But *illness* is the experience of living with a particular disease," he explains. "You're looking at two different perspectives — two different languages."

One of the major goals of the program, then, is to help the students understand what Kumagai calls "the universe of illness" — how culture affects perceptions and definitions of illness and what kinds of problems exist in the disparity of medical care due to socioeconomic conditions.

The program was created through a multidisciplinary committee that included med students. "I got involved in helping to design the new curriculum at the medical school [the school has just undergone its most significant curriculum change in 10 years, according to Kumagai], and one of the committees I was on was tasked with helping design this class," says **Arpi Doshi**, a third-year med student. She says the committee also included physicians from almost all the departments — family practice, pediatrics, OB/GYN, and the medical education office, as well as one other student.

"I think one of biggest things the students felt was lacking [in the curriculum] was sufficient patient contact in the first two years," she says.

"We wanted to create a way that students could understand illness and how patients experience it. This doesn't happen with just one session but with several — getting to know them, their environment and how surviving with illness can change lives," Doshi explains.

Beginning this fall, pairs of medical students will be matched up with volunteer families, at least one member of which has a serious or chronic illness. A total of 85 families have been enlisted through mailings and brochures explaining the program. "The physician also has to give us a release form to talk with the family," Kumagai adds.

This will be a two-year course. During each year, the med students will have four home visits with the families, during which they will discuss different issues concerning living with illness. The major topics, he says, will include:

- **Self and illness.**

The impact illness has on oneself, how the patients see themselves, their plans for the future, what fears they have about the future, and what hopes they have. What have they lost in terms of abilities, hopes, or aspirations? What insights and what kinds of strength have they gained?

- **Illness and family.**

What kind of impact has the illness had on the members of the family? "We're defining 'family' in the broadest sense," Kumagai explains. "It may just be the nuclear family, or it may include the entire social support network — roommate, caregiver, neighbor, partner, teammate. We also want to look at what kind of dynamics go on in the family, and how they impact the way an individual copes."

- **Illness and the health care system.**

What kind of interactions have individuals had with their physician and other health care providers? What are the good and bad things about those experiences? Are the patients' opinions undervalued? Deflected? Do they feel humiliated or embarrassed, or are they made angry? How are they able to negotiate the health care system, in terms of working with insurance companies or obtaining medicine and basic health care?

"We've also asked families if they will allow us to have students accompany them to clinical visits — as extended members of family," Kumagai adds. "We want them to have to wait in the waiting room and see what it's like from the patient's point of view."

Kumagai says he constantly is asked why the program involves students at such an early point in their education. The answer, he says, is simple. "In one sense, they are seeing more of the lay world; our interest in doing this is the fundamental belief that oftentimes the attitudes toward medicine they may have the rest of their career are often imprinted early. We want to get the student to understand the full impact of disease and illness, internalize it, and hopefully carry if through their career."

Will the program affect the quality of care these future physicians will give? "It depends on how effective we are, but I think it will," Kumagai says. "In fact, if they can understand what we are trying to teach them, it will have a substantial impact."

He offers this example: "Say Mrs. Smith comes

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into the office. She is a Type II diabetic and is not taking her meds. If you just look at the disease, you just see a bad patient. But if you also see she is a single mother struggling to make ends meet, that she has to take a bus three hours to the clinic and often has to choose between meds and other life essentials, then you have to change your attitude on how to treat her. In this way, you can perhaps take better care of that patient."

Doshi agrees. "This is where you will learn the social skills of dealing with a patient and their family," she says. "Yes, we will learn all the medical terms, the names of drugs, etc., but understanding what the patient goes through is very valuable to their care. You may also see the variety of how one disease process can affect many different people in many different ways. Also, a lot of students don't have much knowledge of culture differences when they graduate from med school."

In concluding, Kumagai sums up his hopes for this new program: "Once students are working with patients [in their home environment]," he says, "hopefully they will see the patient as an individual who is living with an illness, rather than as a disease that happens to be walking on two feet." ■

HFAP survey earns facility referral status

Stays with JCAHO, now has two certifications

(Editor's note: In the cover story for our September 2003 issue, we examined the growing number of alternatives to JCAHO accreditation. This article takes a closer look at one facility that chose such an alternative and why.)

Russell Medical Center in Alexander City, AL, recently completed a survey process with the Healthcare Facilities Accreditation Program (HFAP) of the American Osteopathic Association (AOA), which has deeming authority to survey hospitals under the Medicare Conditions of Participation. (HFAP is designed to service allopathic [MD] and osteopathic [DO] facilities alike.)

However, Russell didn't abandon its ongoing relationship with the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), but rather sought the additional HFAP accreditation to obtain a status unavailable through JCAHO.

Key Points

- Accreditation alternatives to the Joint Commission on Accreditation of Health Care Organizations (JCAHO) are not necessarily an either-or proposition.
- The American Osteopathic Association is seen as more document-driven, while JCAHO focuses on outcomes.
- Consultants prove invaluable in helping center prepare for Healthcare Facilities Accreditation Program survey.

"We were going for a Rural Referral Center status, and one of the requirements was a certain level of admissions," notes **Jan Landers**, MT (ASCP), MBA, Russell's director of quality services and corporate compliance. "We didn't have enough admissions to be recognized by JCAHO, but we did with AOA, and we met all the other criteria."

(With such status, Landers explains, you can get patients referred to your facility from various other rural community hospitals in the area.)

There are distinct differences between the two survey processes, Landers notes. "AOA is more document-driven, and JCAHO is more outcome-driven, though both have obvious benefits," she explains. "AOA is based almost entirely on Medicare conditions of participation."

By document-driven, Landers notes that AOA actually wants to see what you have on paper. "In terms of patients' rights, for example, the conditions of participation require that there be a certain number of items patients should be told they have a right to," Landers says. "The AOA will look at the actual paper you give to the patient and check those items off one by one. JCAHO is not quite that way; they would go to the patient and say, 'Were you told about your rights?'"

The other significant difference, Landers notes, is that there's not a lot of "surveyor bias" with the AOA. "They go straight by the book," she says. "You either have it, or you don't."

Once Russell made the decision to undergo the HFAP survey, it only had nine weeks to prepare. "We knew we had a lot of work to do in a very short period of time," Landers recalls.

To help in that preparation, "We spent a little money on a nurse consultant and an administrator consultant, much like you can do with JCAHO," she says. "They both looked at our facility and made suggestions."

That was money well spent, Landers says,

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For information on the Healthcare Facilities Accreditation Program, go to:

- www.aoa-net.org/Accreditation/HFAP/HFAP.htm.

because there were no surprises in the survey process. "They were very good consultants," she asserts.

For the immediate future, Russell does not plan to substitute the HFAP survey for JCAHO, but to keep both, despite the obvious financial burden. "We don't see [HFAP] as a replacement; we will keep doing both," she asserts. "We like the JCAHO approach, as well; it's expensive, but we really like to be checked on our outcomes as well."

If it is financially plausible, she says, other facilities should consider going with both surveys. "These are really two different approaches and two different surveys; if you have the money in the budget, it's good to do them both." ■

IOM cites core functions to improve EHR systems

Setting standards prior to widespread adoption

As part of a national effort to encourage the adoption of computer-based health records, an Institute of Medicine (IOM) panel has identified a set of eight core functions that electronic health records (EHRs) should perform to promote greater safety, quality, and efficiency in health care delivery.

"[Secretary of Health and Human Services] Tommy Thompson was very keen on stepping up to the plate to offer incentives for more providers to adopt EHRs," notes **Paul Tang**, MD, chief medical information officer at the Palo Alto (CA) Medical Foundation and chair of the IOM committee that identified the core functions.

"The first question that comes up is: What is an EHR, and what criteria should it use? We were asked to spell out the key capabilities of an EHR in health care settings and to list the things for which there is evidence that, if you had them, you would gain benefits," he adds.

The committee looked at four major issues: quality of care, chronic disease management, efficiency, and feasibility. This last item was as important as the other three, Tang says.

"You can't just say, 'Everyone has to have a full-fledged EHR next year," he explains. "We wanted to lay out what they are, when our best guess is that they will become commercially available, and when we could reasonably expect 'early' docs to have them available. This report will not say, 'The whole country will have it by this particular time.'"

The eight core functions are:

- **Health information and data.** Immediate access to key information, such as patients' diagnoses, allergies, lab test results, and medications.
- **Result management.** The ability for all providers participating in the care of a patient in multiple settings to quickly access new and past test results.
- **Order management.** The ability to enter and store orders for prescriptions, tests, and other

Key Points

- Key elements must address quality, efficiency, and feasibility.
- Committee piggybacks on ongoing study for faster results.
- Common industry standard for software developers being created.

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services in a computer-based system.

- **Decision support.** Using reminders, prompts, alerts, and computerized decision-support systems to improve compliance with best clinical practices, ensure regular screenings and other preventive practices, identify possible drug interactions, and facilitate diagnoses and treatments.
- **Electronic communication and connectivity.** Efficient, secure, and readily accessible communication among providers and patients.
- **Patient support.** Tools that give patients access to their health records, provide interactive patient education, and help them carry out home monitoring and self-testing can improve control of chronic conditions, such as diabetes.
- **Administrative processes.** Computerized administrative tools, such as scheduling systems, to improve hospital and clinic efficiency and provide more timely service to patients.
- **Reporting.** Electronic data storage that employs uniform data standards to enable health care organizations to respond more quickly to federal, state, and private reporting requirements.

The committee's report, which will be published in full this fall, was produced much more rapidly than typical IOM studies. "IOM studies typically last 1½ to two years," Tang notes.

"Fortunately, they had another committee working on a study of data standards for patient safety we could tag onto, so we added our findings to their report," he says.

The plan is for the key capabilities to be used by Health Level Seven, Inc. (HL7) in Ann Arbor, MI, one of the main standard development organizations in health care. "They are developing a common industry standard for EHRs that will guide the efforts of software developers," Tang explains.

Having a common understanding about the key functions that EHR software should possess will allow health care organizations to more easily compare the systems currently available and help vendors build systems that meet care providers' expectations, the report says.

The specification of core functions also will help accreditation organizations and others certify EHR systems that are ready for adoption. In addition, the report says that Medicare and private health care programs are considering providing financial rewards to providers for investing in EHRs with specific capabilities.

The IOM also says that all EHRs must protect patient privacy and confidentiality, and comply with the standards for security, storage, and exchange of data required by the Health Insurance Portability and Accountability Act.

The committee also predicts that by 2010, comprehensive EHR systems will be available and implemented in many health systems and regions. ■

Need More Information?

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Audio conference clarifies final EMTALA regulations

The final version of the recently proposed changes to the Emergency Medical Treatment and Labor Act (EMTALA) takes effect Nov. 10.

To provide you with critical information on the updated regulations from the Centers for Medicare & Medicaid Services, Thomson American Health Consultants offers **New EMTALA Regulations: Are They Too Good to be True?** — an audio conInvitiumference on Tuesday, Oct. 21, from 2:30-3:30 p.m., EST.

While the new rule clarifies many points and is intended to reduce the compliance burden for hospitals and physicians, it's only good news if you implement it correctly. You still could face violations, hefty fines, confusion, and misinterpretation. Find out the answers to these questions:

- How do you provide emergency treatment during a national emergency?
- How does EMTALA apply to inpatients, including those admitted through the emergency department?
- What should be the procedure regarding on-call lists?
- What's the new rule regarding hospital-owned ambulances?
- How are off-campus clinics affected?

Ensure you and your staff are prepared with straightforward advice from a panel of EMTALA experts.

The program will be presented by **James R. Hubler**, MD, JD, FACEP, FAAEM, FCLM, attending physician and clinical assistant professor of surgery, department of emergency medicine, OSF Saint Francis Hospital and University of Illinois College of Medicine in Peoria; and **Robert A. Bitterman**, MD, JD, FACEP, director of risk management and managed care, department of emergency medicine, Carolinas Medical Center in Charlotte, NC.

Our expert advice will help you steer clear of potential pitfalls. "The new rule could aggravate an existing problem," Bitterman told *The New York Times*. "Specialists are not accepting on-call duties as frequently as we would like. As a result, hospital emergency departments lack coverage for various specialties like neurosurgery, orthopedics, and ophthalmology. The new rule could make it more difficult for patients to get timely access to those specialists."

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