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Growth of hospital-based palliative care programs surges

Programs meeting the specialized needs of patient population

If your hospital doesn't have a palliative care program it soon may, if current statistics are any indication. The New York City-based Center to Advance Palliative Care's (CAPC) analysis of data released in the 2007 American Hospital Association Annual Survey of Hospitals shows that 1,240 hospitals now provide palliative care programs. According to CAPC, the total in 2000 was 632.

CAPC adds that of the 4,103 hospitals "appropriate" for palliative care programs (psychiatric and rehab hospitals are excluded):

- 30% have a program.
- 50% with more than 75 beds have a program.
- 70% with more than 250 beds have a program.
- 57% of hospitals with a cancer program approved by the American College of Surgeons (ACS) have a program.
- 75% of Council of Teaching Hospitals (COTH) members have a program.
- 46% of hospitals in cities with a population of 1 to 2.5 million have a program.

The cause of this rapid growth is "multi-factorial," according to **Diane E. Meier**, MD, director of CAPC, director of the Lilian and Benjamin Hertzberg Palliative Care Institute, and the Catherine Gaisman Professor of Medical Ethics Professor,

Key Points

- Palliative care programs can improve quality of care for seriously ill patients in hospitals.
- Facility notes shortened lengths of stay, improved patient satisfaction.
- Multidisciplinary teams have greatest success; coordination of care critical.

Departments of Geriatrics and Medicine, Mount Sinai School of Medicine. "One of the major causes is the growth in the number of patients who live with serious chronic, multiple comorbid illnesses but who do not become well," she says.

"They are completely technology-dependent, requiring dialysis or ventilators. They do not die, but live on, tethered by various machinery, but they do not go home. Another key factor is the enormous investment of the Robert Wood Johnson Foundation in the center, and other initiatives that have blanketed the country with information and training for doctors, nurses, and technical assistants."

CAPC defines palliative medicine as "interdisciplinary care aimed at the relief of the pain, symptoms, and stress of serious illness." Its goal is "to ensure the highest quality of life possible for patients and their families."

Why a specialized program?

But these patients already are being treated in hospitals; why is a specialized program required? "This group of patients is really not well served by standard treatment in hospitals," Meier asserts. "They work very well for the average patient, but they do not work well for the smaller number of outlier patients who are the most sick and typically have comorbid illness. They tend not to do well and are enormously costly for hospitals, so palliative care is needed for this small number of high-level suffering patients."

These patients, she continues, require "comprehensive and expert symptom assessment and management." Sophisticated communication skills are required to help seriously ill patients and their families understand what their real choices are, she explains.

"You have to give them the information they need and support them in their choices," says Meier. "If their prognosis is limited, they may choose to spend their remaining weeks of life at home, as opposed to languishing in the ICU for weeks or months. If they are unable to come off a ventilator, once the family understands that this means the patient is unlikely to ever come off it, they may choose to remove them from the ventilator."

What a program looks like

The structure of the palliative care team can vary based on the size of your hospital, notes Meier. "If you have 300 beds or more, the interdisciplinary team at a minimum usually includes a nurse, a social worker, and a physician," she says. "Preferably, they have some form of advanced training and accreditation."

They usually are admitted by referral from their primary care provider, says Meier. "Some hospitals have screening programs with specific criteria, such as stage 4 metastatic cancer, or hospitalization of longer than two weeks, which are triggers for referral," she adds.

Mount Carmel Health System in Columbus, OH, has palliative care programs in all three of its hospitals, and all have similar staffs, notes **Mary Ann Gill**, MA, RN, executive director for palliative care services. "The units are staffed by

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hospital employees who have a primary interest in palliative care and may also work in another unit," she says. The interdisciplinary team includes nurses, social workers, pharmacists, and chaplains. "The palliative consult service includes a palliative care physician and/or tenured nurses," she adds. "They round every day in a structured rounding process and reassess patients every 24 hours; they also see patients in the rest of the hospital."

"By the very nature of palliative medical service, a huge part of it is communication and coordination between all disciplines and sub-specialists," notes **Philip Santa-Emma**, MD, medical director, palliative care services at Mount Carmel. "Being primarily a hospital-based program, we are able to be there when the families are there and we have the time, the expertise, and the skill set to meet with families and understand multiple issues — and integrate the care away from the subspecialty focus to the patient as a whole. This way, we really help bring the big picture into focus and develop a plan of care that utilizes the resources we have — and uses them for the most appropriate form of care."

Creating a program

The Mount Carmel program began operating in 1997, Gill recalls. Prior to that, she was the director of a community hospice owned by the Mount Carmel system. "I attended a conference in Phoenix where people were talking about pain management in hospitals," she recalls. "The folks who were there from hospitals were very surprised by what they heard, but I wasn't. This made me think about the knowledge gap in hospitals."

She started working with hospitals in her system, sharing evidence-based information. "We realized we did have some information that was useful to hospitals, but that we also had a lot to learn about their needs," Gill says.

After learning more about chronically ill patients in hospitals from these discussions and from the Support study (which was conducted from 1990 to 1994 at five different university hospitals around the country and which evaluated how end-of-life patients were dying), Gill put together a group of physicians and asked if they would consider looking at a new and different program for this patient population. "We started working on a pilot program and began looking at programs that had already been started; Northwestern was our benchmark," she says. "We went there and studied them."

She was fortunate, she says, that experts were available within the Mount Carmel system. "We started with small bits and pieces of FTEs," says Gill. "We felt physician presence was important because they tend to be the people who either open doors or keep them closed to referrals."

As the program grew, so did the FTEs. "We started two units; our rationale then was to have those units and train staff to be competent in pain management. Within the next three years, the system had another hospital and we now have three units."

The program interfaces with the quality department, but it also has a database of its own, says Gill. "Since it's a new program, we wanted to be able to track what happens with our patients," she explains. The program has a rounds worksheet that helps keep track of patients' diseases and symptoms, and those data go into the database.

"We also have some benchmarking measures we keep and that we feel are very important," adds Gill. "We collect them, analyze them, keep them on a dashboard, and report to the centralized quality committee."

Mount Carmel also compares its performance with other facilities, says Gill. "We want to make sure we manage basic pain and key symptoms within a specified period of admission — for

example, within 48 hours we should address and reduce pain and order other, appropriate pharmacological therapy," she says.

Quality measures also include conducting family meetings to gain consensus on how care should proceed; showing evidence of care coordination; and making sure discharge planning is being used by day 3 (average LOS is 3.6 days).

To ensure the highest possible quality in a palliative program, Meier advises quality professionals to examine the criteria, standards, and guidelines that underlie a good palliative care program and identify the "crosswalks" between different standards organizations. (CAPC provides a list of guidelines as well as charts illustrating these crosswalks on its web site, www.capc.org.)

"This way, you can help the palliative care team to integrate into their clinical work the measurements and reporting that are the bread and butter of a quality expert," she explains. "Help them establish guidelines and learn how to measure and put in place QI for areas in which you fall short. This is imperative."

If your hospital doesn't yet have a program, you can learn about how to negotiate with your administration on the CAPC web site, says Meier. "Once you get started, be aware there is a huge range of programs, quality, and adherence to guidelines," she add. "Support the growth and development of your program to help make it as good as you can." **(Leading organizations are working to standardize hospital-based palliative care programs. See related story, this page.)**

Outcomes improve

Gill says she has seen considerable improvement in outcomes with the institution of the palliative care program. "One of the things we saw before the program was that these patients did come in the hospital and stayed for a long time, but given all that time and effort, they did not necessarily have great outcomes; they still had a high potential for dying in the hospital and not being transferred to hospice care," she says. "Even if they were not appropriate for hospice, they needed to be managed uniquely, but we could see they spent a lot of time in uncoordinated care, or staff did not have time for the family to express what their wishes were."

The old data, she continues, showed that patients who were very sick — with end-stage heart disease or lung cancer, for example — spent their last 10 days in the ICU and died there. "Now, when they enter the ED, they may go to the ICU, but there will be a palliative care discussion," she notes. "The ED now has specific triage triggers for such discussions." If they go directly into palliative care, she says, "We can reduce their symptoms, keep them stable, and discharge them in three or four days. Previously, they would be here for 10 to 13 days."

Gill says the program has had a positive impact not only on quality, but on utilization, volume, LOS, occupancy on units, and overall patient flow.

Patients and their families have a positive perception of the program, says Gill. "When we ask them if they would recommend this care to someone else, 85% say they definitely would," she notes, adding that these responses come both from families of patients who died and from families of patients who were discharged.

The keys to a successful program, says Gill, begin with a strong team. "You really need interdisciplinary involvement, and a good balance of doctors and nurses," she says. "I also think programs struggle if they do not have a clearly articulated plan for growth, because growth will occur fast, and you don't want to burn out your staff." Gill knows whereof she speaks: Her program has been designated as a Palliative Care Program of Excellence by the Robert Wood Johnson Foundation, and has been asked to train other health care systems to start their own palliative care programs.

Having good data also is critical to your program's success, says Santa-Emma. "There will come a time when the system comes and says, 'What are you doing and how well are you doing it?'" he points out. "If you do not have the data, all you can say is that it feels good, or, 'The patients like us.' You'll never survive with that; being able to describe your program in detail to anyone who asks is vital to showing the value your program has to the system as a whole."

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Clinicians seek program to program uniformity

While the rapid growth of hospital-based palliative care programs is the good news, the bad news is the wide range of quality and standards that exist, notes **Betty Ferrell**, PhD, RN, research scientist at City of Hope National Medical Center in Los Angeles and chair of the National Consensus Project for Quality Palliative Care (NCP) Task Force.

"It is wonderful if Mercy Hospital in Des Moines and M.D. Anderson in Texas start programs, but what is more important from the patient's perspective is that there is some uniformity in programs," she asserts.

The fact that of the 2,000 plus hospital-based programs no two are alike is "a huge challenge," Ferrell continues. "What if you had a wonderful experience with your mom in your town but grandma is 100 miles away and gets sick, and you tell your brother he should definitely get her into a program? You might then find out the staff is an art therapist and a social care provider."

The idea behind the task force, she says, "Is that we need a common definition and an assured framework, so consumers and payers and accrediting bodies can begin to have some shared understanding of what this is all about."

The NCP has taken significant steps in this direction, says Ferrell. "If you go to our web site [www.nationalconsensusproject.org], there are eight domains — a sort of simple template," she points out. The domains are: structure and process of care; physical; psychological and psychiatric; social; spiritual, religious, and existential; cultural; the imminently dying patient; and ethics and law. The NCP site also includes clinical practice guidelines and other detailed information on what a palliative care program should include.

"If you have a program now, or are starting one, refer to these. This is what will direct the future of reimbursement and accreditation, and you can look at them and assess how you are doing," Ferrell suggests.

Within the next couple weeks, for example, the National Quality Forum will have available on its web site written preferred practices for the field, after having reviewed the NCP's clinical practice guidelines, according to Ferrell. "We served on the NQF group, and they have developed preferred practices for each of our eight domains," she adds. "These measures indicate where the field is going."

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Study shows link between safety and satisfaction

Two-way connection for hospitals

A new study initiated by patient satisfaction firm Press Ganey Associates Inc., of South Bend, IN, appears to show a strong correlation between hospitals that perform well on their patient satisfaction surveys and the stronger performers in the publicly reported Leapfrog Hospital Quality and Safety Survey, sponsored by the Washington, DC-based Leapfrog Group.

For example, the study shows that Press Ganey clients are more likely than non-Press Ganey clients to achieve either good progress or fully implemented ratings for CPOE, ICU physician staffing, and the Leapfrog Safe Practices Score, key measures in the Leapfrog survey.

Leapfrog uses four classifications, in ascending order: willing to report, good early-stage effort, good progress, or fully implemented.

"The average score of a hospital that does participate in Leapfrog is almost a year ahead of the average score achieved," explains **Deirdre**

Key Points

- Focus on patient satisfaction does not come at the detriment of focus on safety.
- Patients notice staff safe practices, such as using computers for prescriptions or washing hands.
- Hospitals that show transparency are more able to overcome challenges in patient satisfaction.

Mylod, PhD, vice president of public policy at Press Ganey.

Conversely, those Press Ganey clients that share their quality and safety information with Leapfrog have statistically higher patient satisfaction scores than hospitals that did not volunteer information. The mean score for the 226 Press Ganey clients who also submitted data to Leapfrog was 84, compared with a score of 82.7 for the 176 clients who were not willing to submit data. "The mean score difference between the two groups represents a difference of 20 percentiles when comparing each mean score against the national database," explains Mylod.

"This study starts making that link between patient experience and public reporting of public safety initiatives and hospitals' focus on patient safety and the care they provide," adds **Catherine Eikel**, director of programs at the Leapfrog Group. "We see through this analysis that a hospital's focus on patient safety does translate into more satisfied patients — those hospitals that focus on patient safety are more likely to be more patient-centered; their patients receive the safest care and are satisfied with their stay."

Not a zero sum game

The study was initiated by Press Ganey as a follow-on to earlier research. "We had done a previous study where we linked patient satisfaction to the publicly available clinical data on Hospital Compare," notes Mylod. "Higher clinical quality correlated with higher satisfaction."[1]

Quality, she continues, "Is not a zero sum game. That is, this is not a situation where focus on patient satisfaction is at the detriment of focus on safety — or vice versa."

Since Leapfrog makes its data publicly available, she continues, you can purchase its dataset for research purposes. "Our hypothesis was that there would be a relationship somehow," says Mylod.

How does Mylod explain the results? "What we found was that, in fact, hospitals that voluntarily submit data to Leapfrog have statistically significantly higher satisfaction scores with our data," she observes. "In order to do this, you have to be willing to be transparent." That entails a willingness to publicly share the "bad" news of your performance results as well as the good, she emphasizes.

In addition, she says, you must be willing to spend the time and the resources required to gather the data. "Having done all of that is a 'flag' for a hospital that seems better able to provide a higher quality of care — and their patient evaluations are better," she asserts.

Part of the reason for the link, adds Eikel, is that a hospital's efforts to provide safer care, in addition to being publicly reported by Leapfrog, do not go unnoticed by patients during their stay. "Some of the things hospitals do to meet Leapfrog standards are highly visible, like a CPOE system," she explains. "The patient can see the doctor is entering their prescription in the computer, vs. writing it down. They can also see when the doctor is washing his hands — and a careful consumer should be keeping a lookout for such practices."

The public, she notes, is becoming much more aware of aspects of patient safety they should be looking for. "And more importantly," she adds, "they are becoming more aware of what to look for when they are helping with the care of a loved one."

The study's results, Mylod adds, underscore the importance of pursuing improvement in patient quality and safety, and of publicly reporting those results. "Participating in Leapfrog appears to be a flag for a hospital that is actively engaged on a quality journey," she says. "Among Press Ganey clients, Leapfrog hospitals are also getting better faster ... in particular, Leapfrog hospitals in the 'good early-stage effort' category have the greatest positive change in patient satisfaction over a year."

Being a Leapfrog hospital, she concludes, "Is also a flag for hospitals that are more able to overcome significant quality challenges on the patient satisfaction side. Those who are faced with low satisfaction performance but who participate in Leapfrog appear to be better able to improve patient evaluations more rapidly."

Reference

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VHA initiates regional RRT collaborative program

Recognition process takes note of top performers

VHA West Coast, based in El Segundo, CA, has successfully launched a regional collaborative for rapid response teams, which it has made available to 118 acute care hospitals in six states. "Our overall goal was to help our member hospitals improve their economics and quality performance through a collegial, networking collaboration in which they shared best practices," says **Patricia Tyler**, RN, CCRN, director of performance improvement.

VHA, in fact, has a number of such initiatives under way, but in the past year a new element has been added: a recognition process for the top hospitals. "QI is not always easy, and you don't always get a pat on the back," Tyler notes. "This program recognizes hospital teams and frontline staffs. We created several different award categories, including individual awards."

This year, says Tyler, VHA was able to present awards to 12 hospitals within the region.

Key Points

- Twelve of 188 facilities in Western region earn recognition for high-level performance.
- Efforts supported with face-to-face and satellite sessions, e-mail, and phone conferences.
- Programs seek to empower anyone to initiate team call — even patients and family members.

Collaborating for excellence

The collaborative has been in place for about a year. Many of the facilities got together for face-to-face meetings, but four satellite sessions were held for those facilities whose representatives couldn't come on site, such as those from Hawaii and Alaska. "We had the regional meetings, national VHA Inc., support meetings, and information was also provided to them via e-mail correspondence," notes Tyler. "We also had conference calls in which members could talk and share experiences with each other. We have found the best learning takes place when hospital teams can come together and share each other's knowledge, experiences, and barriers. For instance, where one hospital might see a barrier, another may have already solved the problem."

In order for a hospital to qualify for an award, notes Tyler, they had to have participated in the collaborative. "They had to have improved from the last year to this year by a certain percentage, and submit data as part of their measurement to show improvement — to show if the interventions were making a difference," she explains. "We particularly looked at significant improvement in preventing codes outside of the ICU, decreasing unnecessary transfers to the ICU, and decreasing mortality from unexpected codes."

The facilities also were asked to identify their champions, and to share what, in many instances, were compelling stories. "This was an opportunity for them to really share what their best practices were and make it understandable and readable for other teams," Tyler explains.

Then, at the awards ceremony, the winners made brief presentations. "They felt good not only because they were being recognized for their work, but also because they were being supported and recognized amongst their colleagues from other hospitals," says Tyler. "They were able to convey a compelling message to the other teams about quality and safety."

Rapid acceptance seen

One of the award-winning facilities, Sutter Delta Medical Center in Antioch, CA, readily integrated the rapid response team program when it was launched in April 2006, recalls **Darci Dumford**, RRT, manager of the cardiopulmonary and cath labs. "We saw dramatic increases in the call for rapid response teams almost immediately; there were no barriers from anyone," she states. "It was a positive effort to put our patients first and get them taken care of, and it continues like that."

The Sutter Delta team includes the charge nurse from ICU and a respiratory therapist. "Anybody at all can call the team; all you need to do is have a suspicion something is not right with the patient," Dumford explains. The calls can be made for "any reason at all," she adds.

Family members can call the team as well, says Dumford. "There has not yet been an educational push to family members, but if they approach a nurse and say there has been some change in the patient's status they can call."

Housewide, there has been a "huge" educational push, with posters up in numerous areas

of the facility and educational sessions for all departments.

Despite the fact that there are no restrictions on who can call — or why — there has been no problem with unnecessary calls, reports Dumford. "The whole experience is supposed to be an educational opportunity," she observes. "Even if a nurse on the floor who is not that experienced calls for a rapid response and the group arrives [and determines the call was not necessary], they work on educating that person. It's all about our focus on putting the patient first."

Setting protocols

The program at John Muir Health, Concord (CA) Campus, another award winner, was a little more structured, notes **Karen Denham**, RN, CCRN, director of critical care telemetry. "The medical staff got together and created a set of protocols for nurses to implement in treating the patient," she notes. "There are specified treatments for patients with chest pain, shortness of breath, and patients with very low blood pressure."

The Muir program, which launched in March 2006, also involved staff education sessions. "We had a lot of discussion about what a rapid action team was, and what its purpose was," Denham recalls.

The team is comprised of a critical care RN and a respiratory therapist, notes **Rhonda Polder**, RN. "Any staff member can call; we are working through the process of having families and patients call, but it's not in place yet," she reports. "We just need to make sure our communication system can support it and that we will be able to handle the increased volume of calls."

While there are specific clinical criteria, Polder is quick to point out that, "Literally, the first criteria is that you're worried." While that is a broad criteria, "We do want to make sure the team is used well and appropriately so we can support it," she adds. "It will require some patient education, and we are putting that together."

So far, she says, the response to the team has been "fabulous." She says that while they are evaluating the program, they are simultaneously conducting an RN satisfaction survey for every call that goes out. "The response has been overwhelmingly positive; it is seen as such a supportive [program for the nurses]," says Polder.

Polder notes that the collaborative model has been extremely valuable. "I think it helped us get off the ground," she asserts. "It got us the key information we needed to make sure we were responding to the right kinds of calls and that the program was implemented appropriately."

"VHA has been so helpful in connecting us in any different phase of implementation with someone who had already implemented it, and who had sustained positive results," Dumford notes. "They also provided easy access to tools someone else has used successfully."

Tyler notes that the program's benefits extend beyond the obvious patient care impact. "It also engenders an increase in nurse satisfaction and empowerment; they feel they are being supported in a team environment, and in some cases, they are learning from more experienced nurses," she says. "We're even seeing increased nurse retention because team leaders support that type of environment and culture."

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Patients view errors more broadly than clinicians

Understanding patients' perceptions is a must

Even though you may be meeting all of your clinical guidelines for preventing errors, your patients may not necessarily share your assessment that things are going well. A new study in the *Joint Commission Journal on Quality and Patient Safety* reveals that patients have a much broader definition of medical errors than clinicians.[1]

For example, notes the study, patients' definition of medical errors included not only clinical mistakes but patient falls and staff not communicating effectively or not being responsive to patient requests. The study, which surveyed patients discharged from 12 Midwestern hospitals, found that while 94% believed their medi-

cal safety had been good to excellent, 39% experienced at least one error-related concern.

The study was part of a larger grant from the Agency for Healthcare Research and Quality, explains **Thomas E. Burroughs**, PhD, lead author and director of the Center for Outcome Research, St. Louis University.

"We wanted to learn what patients are concerned about, what behaviors should be part of precautions against errors, and what they should do in talking with providers," he notes. "This particular study looks at how they view their health care experience from the perspective of the risk of having various types of medical errors happen to them."

In a series of focus groups, he continues, the patients were asked to describe what the term "medical errors" means, "and what might lead them to develop certain viewpoints."

Expanding the definition

One of the things that became instantly apparent, says Burroughs, is that when patients thought about patient safety and medical errors, they "expanded beyond traditional clinical medical definitions." This expansion, he adds, included communication, coordination of care, and the way in which they were treated as people.

"They talked about things that in a way made some sense in regard to errors," he offers. "If a doctor or nurse is not speaking clearly with a patient about how they need to care for themselves, or prepare for a procedure, they may not understand the provider and may be less likely to do what they need to do. Yet, as a clinician, you often don't think about those things in terms of errors or safety."

Where the "rubber meets the road," he says, is whether a patient feels safe. "It's important to realize that when we use certain language, the patient may not interpret it the way we mean

Key Points

- Patients' definition of medical errors include staff not communicating effectively, or not being responsive to patient requests.
- While 94% of patients believed their medical safety had been good to excellent, 39% experienced at least one error-related concern.
- "Perception gap" can have a significant impact on efforts to improve patient safety.

it," Burroughs emphasizes. For example, he notes, if you are seeking to engage patients in programs that help them reduce their risks, and you only talk about keeping track of their meds, or noting if providers are washing their hands, "you may not be going far enough."

This confusion, he says, might lead to odd provider/patient conversations. "You might, for example, ask the patient to tell you any time they think something is happening that puts them at risk, but when they come and talk to you about coordination of care, you might think they are talking about service," Burroughs offers. "But they think they are doing what you asked. On the other hand, if we talk about the risk of errors and don't talk about things like communication and coordination of care, it may seem to the patient that we are missing a big part of what they consider to be medical errors."

Satisfaction impact

Failing to recognize these important patient perceptions can be a big issue if you are seeking to improve patient satisfaction, says Burroughs. "It's important to know what the patient's definition of safety includes," he says. "If that information is being used to launch structural and process changes to improve safety, it makes some sense to improve communication and coordination."

Along those lines, it's also important for the hospital staff to recognize that the age of the patient has a lot to do with a patient's — and family's — perceptions of safety. "There's a pretty clear distinction by ages," Burroughs asserts. "For example, parents of pediatric patients are more concerned about patient safety than anyone else. There was a significant drop [in concern] by patients in their 20s, but then it rose considerably for patients in their 30s and 40s; then it dropped again."

It's important to remember that fears and concerns may be very different for different patients, he continues. "Older patients may come in with a much safer feeling than patients in the 30-50 range," says Burroughs.

That also can be an important consideration when engaging a patient in an error prevention program. "Normally, you might tell the patient they need to make sure their meds match what they expect to receive, that they should ask staff if they are washing their hands, and so forth," he offers. "But for patients in their 60s to their 80s, it may be disturbing to them because they may not have previously felt they were at risk, because it did not coincide with the way they look at the health care experience."

For parents, on the other hand, it's critical to help put them at ease. "Explain the checks and balances, and tell them what they can do to help you put their child at less risk," he concludes.

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Balance Center aims to prevent falls

Hospital considers wellness part of mission

While Robert Wood Johnson (RWJ) University Hospital Hamilton (NJ) is as committed as any other facility to provide quality care for its inpatients, the leaders of the hospital believe their responsibility to the well-being of local residents extends far beyond its four walls.

In fact, RWJ has made a substantial investment to demonstrate that commitment, building an 86,000-square-foot Center for Health & Wellness. The newest program in the center is called a Balance Center, targeted at preventing falls, which, according to the National Center for Injury Prevention and Control, are the leading

Key Points

- Falls are the leading cause of injury deaths and the most common cause of nonfatal injuries and hospital admissions for trauma among adults 65 years and older.
- Center is response to physician requests for referrals of patients with balance problems.
- Hospital's standard nursing assessment includes grading patients on whether they may be a fall risk.

cause of injury deaths and the most common cause of nonfatal injuries and hospital admissions for trauma among adults 65 years and older.

The Balance Center provides diagnostic and rehabilitation services for individuals with a history of falls, inner ear disturbance, Meniere's disease, stroke, head trauma or vestibular (inner ear) disorders.

"Over 90 million people in the U.S. have experienced dizziness or balance problems," notes **Michael Long**, PT, MS, MBA, executive director of ambulatory care. "In the community we noticed that a lot of people were asking for information on how to prevent falls; our audiologist received a call asking if we performed VNG [videonystagmography, which identifies the root of a balance problem] studies, and physicians had asked if there was somewhere they could send patients who have balance problems."

All well and good, but shouldn't a hospital be concerned more with patients who have problems, rather than those who might develop them?

"We want to keep people out of the ED," says Long. "Our mission is to promote the health and wellness of the community."

By pre-screening individuals in the community, he continues, "we can predict fall risk. Our hope is that with these screenings we can get to them before they have falls and keep them out of the hospital."

VNG is core service

When a patient comes to the center, "The first thing that is done is the VNG test," says **Jason Homowitz**, PT, MS, MBA, the program's clinical supervisor. "Based on the test, the audiologist will create a summary of findings, and physical therapy will cater a balance program for the patient."

The physical therapist will perform a fall track assessment, which involves having the patient stand on a diagnostic board and focus on a grid. "It measures body sway based on responses with the eyes open and closed, while standing on both a rigid and on a perturbed surface," Homowitz explains.

The "cure," he continues, consists mainly of vestibular therapy, which works by having the patient perform motions that are intended to make them dizzy, while at the same time requiring them to focus on their body position and coordination. This helps the brain compensate for lost balance more quickly.

While such therapy would clearly mitigate the chance of these individuals falling should they ever be admitted to RWJ, Long is quick to point out that the staff in the hospital are not relying entirely on the new program to identify these at-risk individuals. "There are now two ways the hospital works to identify patients at risk for falls," he explains. "Part of the standard nursing assessment is that they grade the patient on whether or not they may be a fall risk. If they are, they are identified as such throughout their stay. Then, whenever a patient comes to rehab we do a kinetic balance test, to make sure they are not a fall risk as well." ■

NEWS BRIEFS

Docs get free electronic prescribing software

A coalition of technology companies, health plans, and providers will be offering electronic prescribing software free to all physicians. The National ePrescribing Patient Safety Initiative will offer software by Allscripts, called eRx NOW, free to any health care provider with legal authority to prescribe medications. According to the coalition, the software requires no download or new hardware and minimal training, and all

COMING IN FUTURE MONTHS

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patient information will be stored on remote servers in a secure location. Sponsors of the program include Allscripts, Dell Computer, Cisco Systems, Fujitsu Computers of America, Microsoft Corp., Sprint Nextel, Wolters Kluwer Health, SureScripts, Google, Aetna, and WellPoint. ▼

Pennsylvania quality alliance formed

A group of Pennsylvania health care providers and insurers has formed a new organization, the Pennsylvania Health Care Quality Alliance, to "foster transparency in health care and improve patient health." During the next year, the goals for the Alliance are: "To develop a consistent, uniform, statewide approach to measuring health care quality, and to report useful information to both providers and the public using measures that have already been developed and endorsed at a state or federal level, and leveraging existing data sources."

The alliance seeks to enable consumers and businesses in Pennsylvania to compare provider performance, help providers evaluate and improve the quality of their patient care, and enable insurers to evaluate the performance of their provider networks.

Alliance participants include the Hospital & Healthsystem Association of Pennsylvania (HAP), which represents more than 225 hospitals and health systems across the state; the Delaware Valley Healthcare Council of HAP; the Hospital Council of Western Pennsylania; the state's four "Blue" plans; the Pennsylvania Medical Society; representatives from the governor's Office of Health Care Reform; and the U.S. Department of Health and Human Services.

The alliance intends to focus on measures that will be drawn from those already developed and endorsed by such groups as the Hospital Quality Alliance, the Ambulatory Quality Alliance, the National Quality Forum, the Centers for Medicare & Medicaid Services, The Joint Commission, the National Committee for Quality Assurance, and specialty societies. ■

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