

JUNE 2010

For Medical Staff members
at CCH, HRMC, and PBH

*Your vital source of information for
Health First medical quality initiatives*

In this Issue (article lead-ins and links at right)

Quality Leads:..... 2-3

Clinical Integration: An Overview

*By HF Chief Medical Officer/ Chief Quality Officer
Jim Palermo, MD*

IT News You Can Use: 4-5

Order Management coming this Summer

*By Medical Director of Clinical Informatics David P. Hurwitz,
MD, FACP*

Calendar Checkup: 6

June/July 2010 CME offerings, Medical Staff meetings, and special events.

Special Supplement:.....7

“Hurricane Season 2010: A physician’s guide”

*By Rodney Moore, MD, CCH VP Medical Affairs;
Jacqueline Llinas, MD, PBH Medical Staff President;
Scott Gettings, MD, HRMC VP Medical Affairs; and
William Morgan, MD, Health First Physicians*

NOTE: Look for the printed version of the June 2010 Physician e-Xcellence Special Supplement: “Hurricane Season 2010: A physician’s guide” (included in this electronic version on page 7) that were also distributed in Medical Staff mailboxes during the first week of June 2010.

Physician e-Xcellence is published by Health First for physicians on the Medical Staffs at Cape Canaveral Hospital (CCH), Holmes Regional Medical Center (HRMC), and Palm Bay Hospital (PBH).

Editorial Staff

Editor-in-Chief—James V. Palermo, MD

HF Chief Medical Officer/Chief Quality Officer, Health First

e-Physician and IT Contributing Editor—David P. Hurwitz, MD

HF Medical Director of Clinical Informatics

Editorial Administrator—Linda Waits-Kamau

We welcome your feedback, suggestions, article submissions and other input.

Please contact the Editorial Administrator, Linda Waits-Kamau, at Health First Administrative Offices, 6450 US Highway 1, Rockledge, Florida 32955. Tel 321.434.4330 or linda.waits-kamau@health-first.org

Contributing departments include Risk Management, Corporate Compliance, HIPAA, Clinical Informatics, Physician Informatics, Health Information Technology (e-Health Strategy), Continuing Medical Education, and the Medical Staff Offices.



Quality Leads:

Clinical Integration: An Overview *By HF Chief Medical Officer/ Chief Quality Officer Jim Palermo, MD*

Clinical Integration, with its promise of engaging both independent and employed medical staff, is becoming increasingly prevalent as the optimal mechanism for creating what is referred to as accountable systems of care that expand coverage, reward effective and efficient care, improve quality, ensure care coordination, and encourage innovation, all while helping to control costs.

[Read complete article](#)



IT News You Can Use:

Order Management coming this Summer

By Medical Director of Clinical Informatics David P. Hurwitz, MD, FACP

From my perspective, OM is the largest, most complex and challenging clinical IT project in which I have been involved at Health First to date. OM will impact nearly every caregiver as well as a number of ancillary departments (e.g., Pharmacy, Lab, Radiology) within the Health First system.

[Read complete article](#)

Calendar Checkup:

June/July 2010 CME offerings, Medical Staff meetings, and special events. [Read complete article](#)

Special Supplement:

Hurricane Season 2010: A Physician’s Guide.

[Read complete article](#)

*Your vital source of information for
Health First medical quality initiatives*

Quality Leads:

Clinical Integration: An overview

By HF Chief Medical Officer/ Chief
Quality Officer Jim Palermo, MD



As the dust settles from the national debate on healthcare reform and the elements of the Patient Protection and Affordable Care Act come into focus, the key theme that emerges is the growing requirement for more effective platforms that link physicians and hospitals in shared pursuits to improve the quality and efficiency of care. While the details of payment methodology reform are yet to be determined, the imperative that leading health systems are facing is to prepare for this era of accountable care while remaining successful across the transition period, in which reimbursement still follows existing models and incentives remain volume-driven rather than value-based.

Clinical Integration, with its promise of engaging both independent and employed medical staff, is becoming increasingly prevalent as the optimal mechanism for creating what is referred to as accountable systems of care that expand coverage, reward effective and efficient care, improve quality, ensure care coordination, and encourage innovation, all while helping to control costs.

The integral components of a high-performing, accountable care model are:

- An enhanced role for physicians in defining and driving quality of care
- The provision of a data infrastructure linking and providing visibility into the full continuum of care
- The potential to engage payers and the broader community in the provision of this higher value care
- The realignment of physician incentives toward high-quality, efficient, coordinated care

What is less clear for many organizations is the path from here to there.

Defining Clinical Integration can be tricky. Visit the various healthcare organizations around the nation with initiatives in place and they can look very different from each other. What tends to unite Clinical Integration efforts is the focus on encouraging and enabling collaborations among different healthcare providers and sites to ensure higher quality, better

care coordination, and more efficient services for patients.

According to the Institute of Medicine: “Clinical integration facilitates the coordination of patient care across conditions, providers, settings, payers, and time in order to achieve care that is safe, timely, effective, efficient, equitable, and patient-focused.”

Our present model of care is dominated by fragmentation and reimbursement by fee-for-service.

Nothing in the common model of provider-provider and provider-payer relationships assures an optimal level of care coordination, and care is often fragmented as patients move among different providers and across different care settings. Hospitals and physicians have limited tools they can use to positively influence each other’s practice patterns to achieve optimal patient outcomes. In fact, diverse non-integrated systems and locations of care, which are not patient-centered or focused on providing seamless continuum of care, often compete and create significant system navigation challenges for patients. Although payers are focused on integration to a degree, fragmentation still dominates care covered by most health plans, and is reinforced by the failure of the current payment system to recognize and pay for care coordination.

“In fact, the present fee-for-service model, which is based on individual “transactions,” rewards overutilization of services and fails to recognize differences in provider quality or performance.”

By encouraging the use of high-margin services rather than low-cost alternatives, payment is based on market leverage rather than healthcare value. Therefore, incentives among the many diverse healthcare providers necessary to meet the needs of patients across the continuum of care are often misaligned.

As Health First moves forward with clinical integration in the coming months, it's clear that our efforts must be based on realistic integration strategies, operational tactics, capabilities and targets, and a sustainable business model that results in more effective and efficient care delivery that's compatible with and responsive to industry changes.

Our objectives are to:

- Deploy the right care, in the right place, at the right time
- Coordinate patient care across conditions, providers, settings, and time
- Establish systemwide quality, cost standards across all care settings/ modalities
- Drive integration via value-based outcomes
- Establish shared incentives and reward high performers across all care modalities
- Efficiently manage chronic diseases across the system
- Manage diverse populations
- Ultimately (depending on new reimbursement models) assume and manage total risk

Most of all, we must be guided by our ultimate goal — keeping our patients healthy and minimizing their need for hospitalization and costly treatments, while ensuring those high-level care options are available whenever needed.

It's very important to realize that Clinical Integration is not a time-limited initiative or campaign, but a comprehensive transformation of the way we approach care delivery and health management and maintenance.

We are presently closely evaluating healthcare organizations similar to Health First, which have successfully migrated to a clinically integrated, high-performance system of care, and conferring with industry experts in the field of Clinical Integration implementation.

Initially we are focusing on two essential building blocks for Clinical Integration. First, collaborative engagement of key

physicians across the system in developing the fundamental quality and cost standards and value metrics on which this high performance system of care is built. The second is optimization of transitional and post-acute care management based on best-practice care model redesign and collective investment by hospitals, physicians, health plan and community health services in the requisite tools (including IT) and human resources for success.

Successful clinically integrated high-performance systems of care are built upon a partnership between physicians and hospitals or healthcare systems like Health

First. Physician leadership is imperative, and, at the end of the day, doctors must be the drivers. It really is a “Brave New World” in health care today, and we look forward to collaborating with you in this new model to provide greater quality and improved efficiency in delivering patient-centered care to our community.

Key elements to successful Clinical Integration:

- **Provider culture change — a recognition of the harsh consequences of “business as usual,” and a collective commitment to the transformation process**
- **A durable platform for physician engagement and collaboration**
- **The ability to leverage this platform in ways that create demonstrable value for patients, providers, and payers**
- **The negotiation of a business model that rewards this value creation and sustains ongoing clinical and care model innovation**
- **IT infrastructure that facilitates communication and information exchange across the continuum of care**
- **The commitment of all providers and payers to invest human and financial capital in new tools (to include IT inter-operability and integration) and care models (such as transitional care management) to achieve bona fide Clinical Integration**

*Your vital source of information for
Health First medical quality initiatives*

IT NEWS
you can use

**Order Management
coming this Summer**

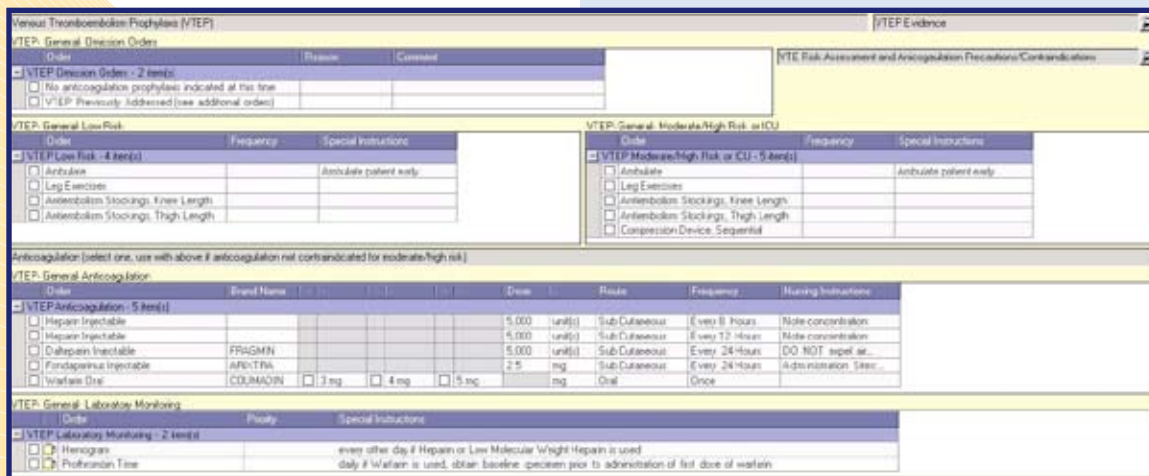
By Medical Director of Clinical Informatics David P. Hurwitz, MD, FACP



This article is a status update on Health First's new Order Management (OM) project, formerly known as Computerized Physician Order Management (CPOM), which is scheduled to begin implementation in the next few months. From my perspective, OM is the largest, most complex and challenging clinical IT project in which I have been involved at Health First to date. OM will impact nearly every caregiver as well as a number of ancillary departments (e.g., Pharmacy, Lab, Radiology) within the Health First system. Additionally, OM needs to work across all three (soon-to-be four) Health First hospitals in a consistent, easy-to-use manner for all end-users. OM's success depends on an unprecedented level of collaboration among all three hospitals, including administrative and physician leadership, Medical Staff, Nursing staff, clinical departments, IT, Clinical Informatics, educators, and various software vendors.

Medical Staff member involvement

As I have emphasized in previous articles, meaningful physician involvement is critical to the success of clinical IT projects. One example of systemwide physician collaboration is the CPOM Physician Design Group. This is a group of physicians from across Health First's three hospitals who met on a regular basis most of last year to help define the look and feel of OM. Their work included developing naming conventions for order sets, defining a basic order set structure including standard naming for order set sections such as admission, diet, IV fluids, etc., as well as what order those order set sections would appear. Additionally, the group helped to address a number of important and complex workflow issues such as consultation. The net effect of these efforts was to create a consistent, physician-centric experience when using OM. Consistency in the look, feel, and structure of OM means it will become more familiar to end-users over time as well as easier to use. Members of the CPOM Physician Design Group have more recently been reviewing the user interface in Sunrise Clinical Manager (SCM) to help optimize its efficiency. In the near future, physicians will assist in "day in the life" testing, which will simulate a variety of physician workflows using OM (admission in ED, admission from practice office, managing orders in rounding workflows, from the office and from home).



Embedding a standardized Venous Thromboembolism Prophylaxis (VTEP) module in admission order sets and requiring that the physician address VTEP before submitting admission orders (see page 5)

Clinical decision support (real-time point-of-care mechanisms that guide, inform, and alert physicians in a way that meaningfully impacts clinical decision-making) is an essential component to optimize patient safety benefits of OM. Examples include:

- Embedding a standardized Venous Thromboembolism Prophylaxis (VTEP) module in admission order sets and requiring that the physician address VTEP before submitting admission orders (see sample on page 4):
- For patients with community-acquired pneumonia, including only antibiotics that are appropriate for a particular patient—e.g., antibiotic options differ for patients in non-ICU vs. ICU settings
- Drug-Drug and Drug-Allergy interaction alerts

It is important that clinical decision support be clinically meaningful and avoid being unnecessarily intrusive. Otherwise physicians will develop “alert fatigue” and will tend to ignore alerts (or not want to use OM) which would undermine the value of clinical decision support. A recently formed interdisciplinary group that I oversee—the **Clinical Decision Support Oversight Group**—has been looking at ways to reduce unnecessary drug allergy alerts in Sunrise Clinical Manager (SCM).



It is important that clinical decision support be clinically meaningful and avoid being unnecessarily intrusive.



Systemwide order sets developed for OM

Another dimension of OM has and continues to be development of systemwide order sets for use in OM. Order sets for use by physicians across our hospitals present two primary challenges:

1. Order sets are not currently widely used across Health First. This is due in part to a lack of efficient mechanisms to access physician orders in Form Imprint. OM will offer anywhere/anytime electronic access to orders in an easy-to-navigate manner, which should spur order set usage significantly.

2. There are multiple order set versions at different Health First hospitals. Since efficient use of OM requires a single systemwide order set for particular conditions, such as heart failure and community-acquired pneumonia, merging previous paper-based hospital versions (many are nearly duplicate efforts) of these order sets into one version has been a major effort. It's important to understand that a single version order set is inclusive of the multiple order sets from which it was derived — it's not cookbook medicine but is meant to accommodate reasonable practice variations across our three hospitals. Physicians practicing at our three hospitals have been assisting in reviewing systemwide order set content. Some also are helping to take ownership of the order set content, which is critical for efficient periodic review and maintenance of the content.

OM implementation

Developing an implementation strategy is another important aspect to optimize OM success. We have decided to take a start-low, go-slow phased-in approach, implementing OM one hospital at a time. Within each hospital, “early adopter” physicians have been identified, who will be the first to enter orders. These will typically be highly motivated physicians who are eager to use OM. In fact, some have used it elsewhere prior to practicing in our area. Prior to using OM, all physicians will be required to attend training classes and will have close support from IT and Clinical Informatics staff after “go live”. Over time, second- and third-wave physician groups will be educated and trained to use OM. The schedule for OM implementation at Health First hospitals is noted below.

OM Implementation Schedule

CCH:	August 15, 2010
PBH:	September 19, 2010
HRMC:	November 14, 2010
Viera:	April 2011

Regardless of whether physicians are entering orders in OM or not, all orders will be available on the Orders Tab in SCM, which is a marked improvement from the current state. Ordering also will be possible from electronic Progress Notes, which will be piloted in the near future.

While OM is enormously complex, challenging, and requires considerable resources to realize, it is also vital in our overall efforts to deliver the best and safest possible care for our patients. It will take time to take root and will require ongoing refinement. However, with ongoing systemwide collaboration, including continuing meaningful physician involvement, OM will become an essential tool in our patient care armamentarium.

Do a checkup on your calendar!

Calendar

June 2010

- 4** CME — **Trauma: A System of Excellence**, Karanbir Gill, MD, Florida Trauma System Medical Director (11:30 am to 1:30 pm, HRMC Auditorium)*
- 11** CME — **Balancing Efficacy and Safety: Individualizing Application of STEMI Guidelines and Performance Measures**, William J. Rogers, MD, UAB Medical Center, Birmingham, Alabama (11:30 am to 1:30 pm, HRMC Auditorium)*
- 18** CME — TBA
- 22** CCH General Medical Staff Meeting, 6:30 pm, CCH Medical Plaza Conference Center
- 22** HRMC General Medical Staff/Department Meeting. Department meetings at 5:30 pm, General Staff starting at 6:30 pm, Melbourne Hilton Rialto
- 25** CME — **Managing Stable Ischemic Heart Disease**, Zilin Wang, MD, Madison County Medical Center, (11:30 am to 1:30 pm, HRMC Auditorium)*

July 2010

- 2** Holiday weekend — no CME program
- 6** PBH Department of Medicine Meeting, 5 pm, PBH Private Dining Room
- 9** CME — **Systems-based Approaches to Improving Patient Outcomes in ACS (EM)**, Douglas Char, MD, Washington University School of Medicine (11:30 am to 1:30 pm, HRMC Auditorium)*
- 12** PBH Department of Surgery Meeting, 7 am, PBH Private Dining Room
- 16** CME — **Atrial Fibrillation: Improving Prevention and Treatment for a Growing Life-Threatening Epidemic**, Michael R. Gold, MD, Medical University of South Carolina (11:30 am to 1:30 pm, HRMC Auditorium)*
- 23** CME — **Central Florida Hurricane Hazards**, Jim Kendig, VP of Health First Safety & Security, and Scott Spratt, National Weather Service (11:30 am to 1:30 pm, HRMC Auditorium)*
- 30** CME — **State-of-the-Art Breast Cancer Care: The Next Decade of Novel Therapies**, Carlos L. Arteaga, MD, Vanderbilt University School of Medicine (11:30 am to 1:30 pm, HRMC Auditorium)*

* For all CME sessions, lunch is from **11:30 am to 12:30 pm**, and the **presentation is from 12:30 to 1:30 pm**. For information and CME records, call **Dee Rogers** at **434-1966**.

PLEASE NOTE: CMEs and mandatories at the HRMC Auditorium are **video-conferenced** into both the **PBH Community Room** and **CCH Medical Plaza Conference Room B**.

June 2010 Special Supplement

Hurricane Season 2010: A physician's guide

By Rodney Moore, MD, CCH VP Medical Affairs;
Jacqueline Llinas, MD, President PBH Medical Staff;
Scott Gettings, MD, HRMC VP Medical Affairs; and
William Morgan, MD, Health First Physicians President

Health First Information Hotline
(activated before impending storm):
321-434-8989
(select Option #4 for Medical Staff updates)

The 2010 Atlantic Hurricane Season, running from June 1 until the end of November, is predicted to see the development of an above-average number of Atlantic basin hurricanes. It's important that all physicians on the Medical Staffs at Health First (HF) hospitals have the necessary information to facilitate the highest level of patient care during any emergency. Storm researchers with the Tropical Meteorology Project at Colorado State University are predicting 15 named storms this season, with eight of those reaching hurricane strength and four becoming "major storms" in Category 3, 4, or 5 on the Saffir-Simpson Scale. The researchers predict at least a 69 percent chance of a major hurricane making landfall along the U.S. Coast, with a 45 percent chance it will be somewhere in the area from the Florida Peninsula westward along the Gulf Coast to Brownsville, Texas. While forecasting hurricanes is an inexact science, the annual predictions remind us that now is the time to prepare. The 2009 season was relatively quiet, with just three hurricanes forming, and none of those making landfall in the United States. It was the kind of year that can contribute to complacency this season, especially among our patients.

(continued on back)

Seasonal reminders

- Each hospital system in Brevard County adopts a Special Needs Shelter and augments onsite medical staffing needs. Once again this year, the shelter at **Quest Elementary School in Viera** is assigned to Health First—with HF Health Plans, HF Physicians, and HF associates assisting at the shelter as needed.
- If your patients are eligible for a Special Needs Shelter, remind them that they must pre-register for this option each year through Brevard County Office of Emergency Management at **321-637-4088**.
- Now is also the time to remind your patients to keep an adequate supply of their medications on hand in case of evacuations due to severe storms. Some community pharmacies have added generator capacity and may be able to open more quickly after a storm, but preparation before any storm warning is still paramount.
- The Pro-Health & Fitness Center in Viera will be utilized as a respite shelter for crucial HF employees as determined and notified by their supervisors, plus Medical Staff members and their immediate family members, based on available space.
- County emergency officials will treat your hospital identification badge as a "pass" during any curfews, allowing you to travel to the hospitals, Special Needs Shelters, and other locations where your assistance is needed.

Inter-hospital cooperation

The Medical Staff Offices at Cape Canaveral Hospital (CCH), Holmes Regional Medical Center (HRMC), and Palm Bay Hospital (PBH) will work together closely during any storm that requires an evacuation at CCH.

- When a hurricane is approaching from the East/Southeast, our plan requires that CCH-based associates and physicians prepare the campus for evacuation. Typically storms approaching from the East or Southeast lead to mandatory evacuation based on Brevard County mandates for evacuation of the beaches and barrier islands. If evacuations are ordered, all evacuated CCH patients will be transferred to HRMC. In the event that HRMC does not have adequate capacity, some CCH patients may be transferred to PBH, which added generator capacity when their hospital Expansion opened last year.
- If a hurricane is approaching from Florida's West Coast, the hurricane plan may be partially activated based on variables such as predicted wind speed upon landfall, plus the direction and strength of the storm once it crosses the Florida Peninsula. Since CCH may not be evacuated, such cases could lead to a "shelter-in-place" scenario, with enough staff staying on-site at CCH during the storm to care for patients who require hospitalization. The emergency generator system at CCH can power critical electrical, cooling, and sewage systems, providing more flexibility during storms that may not require an evacuation and allowing for a smoother re-opening following a major storm.
- If a physician with dual staff privileges at CCH and Wuesthoff Medical Center (WMC) desires that his or her patient be moved to WMC, this will have to be done as a transfer prior to CCH's evacuation, if beds are available, and according to WMC's protocol and approval.

Patient care guidelines

Listed below are HF Medical Staff member care guidelines for the 2010 Hurricane Season, based on discussions between medical directors involved in this process:

- CCH Medical Staff members have the responsibility to provide care for their own patients transferred to HRMC or PBH or personally arrange satisfactory coverage using the guidelines discussed below.
- The Cape Canaveral Hospitalists will provide physician coverage at HRMC or PBH for those patients who've been assigned to their service.
- Health First Physicians (HFP) will provide a group of three to four CCH HFP doctors to cover hospital-practicing HFP patients transferred to HRMC or PBH.
- Non-HFP doctors can request that Cape Canaveral Hospitalists cover their patients if the request is made ahead of time, physician-to-physician. Cape Canaveral Hospitalists have their own assigned patients to cover as well and it cannot be assumed that they can accept responsibility for a large number of transferred patients.
- If physicians who aren't affiliated with HFP aren't able to go to HRMC or PBH to care for their patients and Cape Canaveral Hospitalists are unable to assume care for any reason, they may call a CCH Medical Staff member who practices with HFP and ask about coverage for their patient by that physician who's reporting to HRMC or PBH. Again, this arrangement is made physician-to-physician, and flexibility and early planning are important.
- The referring CCH Medical Staff member is responsible for speaking with the covering physicians during the transfer process, so that any care plans are thoroughly communicated.

During an emergency, the key links in this process will be the CCH, HRMC, and PBH Medical Staff Offices. Our offices will coordinate the list of physicians on call at each hospital and help facilitate the smooth transfer of your patients. The HFP medical group hurricane roster is based on the existing on-call schedule at the time an emergency is declared. Emergency Medical Staff privileges can be granted on a case-by-case basis in keeping with Medical Staff by-laws for each hospital.

Plan ahead and stay aware

As soon as a tropical storm forms, it's important to monitor news media reports and hospital communications for updates. If the storm escalates in strength and our area is in the projected path, physicians need to stay in close contact with their hospital's Medical Staff Office for timely updates about emergency declarations. In addition to coordinating patient transfers before each storm, physicians at all three HF hospitals are expected to:

- Cancel elective surgeries and procedures beginning approximately 30 to 36 hours before predicted landfall to avoid lengthy post-operative hospitalizations that strain the system.
- Assess all their patients for possible discharge 24 hours before an official evacuation order is expected, as we hope to avoid a high volume of discharges on the day of evacuation.
- For physicians working during a storm event, respite space is available at HRMC and PBH, including for physicians' family members. However, you must coordinate this option with the Medical Staff Office as space is limited and it's imperative that all specialties are covered as staffing plans are developed. A limited number of physicians can stay at the Pro-Health & Fitness Center in Viera as noted on page 1.

Emergency information sources

You will receive letters and personal hurricane planning information from your Medical Staff Office. Further information, including specific disaster plans for each hospital, are available on the HF website at www.Health-First.org. During a storm, the Medical Staff Offices will be communicating via pager, phone, or in-person with each and every Medical Staff member who has patients impacted by the emergency. Our offices will also liaison with the large, non-Health First medical practices to help disseminate information.

The **Health First Information Hotline** is accessible at **321-434-8989** and will be updated frequently during any storm emergency, with **option #4** dedicated to Medical Staff-specific information. This information also will be available on the HF intranet, Inside Health First, and through the physician portal on www.Health-First.org.

After a storm

If medical facilities are closed by a storm event, it's important to get them re-opened and functioning as quickly as possible. Local utilities have designated all Brevard hospitals as critical infrastructures with the highest priority for service resumption. HF Physicians and Cape Canaveral Hospitalists have pre-set assignments to assist with patient transfers back to CCH and its re-opening. Because cell phone and pager use may be limited by storm damage, it's each physician's responsibility to check the HF Information Hotline for instructions on when to begin hospital rounds for each HF hospital. It's especially critical that all physicians with pre-assigned, on-call responsibilities be available for duty and either call into the hospital or simply report for rounds as planned. Historically, cell phones, pagers, and answering services are unreliable during and post storm, so it's vitally important that physicians listed on the call schedule take the initiative and responsibility to report for duty and be prepared for possible respite at the hospital.

If you have questions or concerns about any issue during this Hurricane Season, please contact the Medical Staff Office at the HF hospital at which you have staff privileges.

Together, we're better at weathering the storm!