

DECEMBER 2010

For Medical Staff members
at CCH, HRMC, and PBH

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(includes “Night at the Mandatories” sessions in December and January), CME offerings, Medical Staff meetings, and special events

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).

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



Quality Leads:

Re-engineering the discharge process (Project “RED”)

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

Under the Healthcare Reform Bill signed into law by President Obama last March, a new Medicare re-admissions policy will begin penalizing hospitals for potentially preventable re-admissions in 2012. This new government emphasis on aligning reimbursement patterns with Quality goals has spurred hospitals around the country, including Health First, to focus on the discharge process.

[Read complete article](#)



e-Physician:

Mobile computing revisited

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

In an effort to assist physicians in accessing the physician-only network, Health First wants to accommodate as many personal devices as possible, with iPads™ and iPhones™ the most recent additions to the list of personal mobile devices that are supported within HF facilities.

[Read complete article](#)

IT News You Can Use:

Order Management (OM) HF hospital activation schedule

As the computerized entry of physician orders (called “Order Management”, or “OM”, within HF hospitals) is rolled out in our healthcare system, it’s important to understand the phased approach to this process, which will impact physicians in different ways. (The timeline for rollout at all HF hospitals is included.)

[Read complete article](#)

Calendar Checkup:

December 2010 through January 2011

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[Read complete article](#)

Quality Leads: Re-engineering the discharge process (Project RED)



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

Under the Healthcare Reform Bill signed into law by President Obama last March, a new Medicare re-admissions policy will begin penalizing hospitals for potentially preventable re-admissions in 2012. This new government emphasis on aligning reimbursement patterns with Quality goals has spurred hospitals around the country, including Health First, to focus on the discharge process.

This emphasis, however, is just as much about whether we're doing what we should to meet the needs of our patients at that very crucial transitional point of care during the discharge process. It's about ensuring our patients' ultimate health maintenance and keeping them well enough to stay out of the hospital, not just whether or not we'll take a hit on reimbursement.

The existing discharge process at many hospitals is characterized by poor preparation, communication breakdowns, fragmentation of care, and high process variability. Poor discharge instructions lead to poor patient understanding of how to use medications or when to report changes in condition. Poor transfer of information to ambulatory caregivers results in gaps of care as well as confusion and frustration on the part of patients and providers.

Improving the discharge process and enhancing our patients' transitional care management is a priority for all Health First hospitals. We know that accomplishing this will require aligning of incentives between hospitals and physicians and working collaboratively — that partnership creates the best opportunity to reduce waste, meet the needs of our mutual patients, improve quality of care, and optimize the patient experience.

At Health First we've launched a Quality Initiative pilot program in each of our hospitals called "Project RED" (RED stands for "Re-Engineered Discharge"), which is an Agency for Healthcare Research and Quality (AHRQ)-funded program designed to reduce the fragmented care delivery during transitions from one level of care to another, thereby improving Quality, reducing re-admissions and other related costs, and improving patient health and

Physician e-Xcellence

satisfaction. Our initial participation in Project RED is limited to one clinical unit at each hospital with a focus on Congestive Heart Failure patients, the highest re-admission cohort at hospitals across the country. Over a period of six months we're tracking both Process and Outcomes metrics to evaluate the overall efficacy and value of the program, and will make a determination regarding expanding the scope of the program going forward.

"Project RED" Pilot Program Implementation at HF Hospitals

The following units at each hospital where the **Project RED pilot** is in place have been assigned a Discharge Advocate for each facility as noted below:

CCH: 2 North/PCU — Judy Simpson, RN
PBH: 2 South/PCU — Barbara Rhodes, RN
HRMC: D6 — Lara Sexton, RN

Project RED offers healthcare providers the tools to help create a unique "after-hospital care plan" for each patient being discharged. The individual care plan and other elements of the re-engineered discharge enhance patient education, help reconcile medications, confirm appointments, and ensures that the patient's physician receives the discharge summary in a timely manner.

Key Physician Elements to the Success of Project RED:

- Physician maintaining close communication with the hospital's Discharge Advocate to keep the Discharge Advocate informed about plans for discharge.
- Physician discharge Medication Reconciliation completed at the time of discharge.
- Timely (within 24 hours) dictation of the discharge summary with a request within the body of the dictated summary that the discharge summary be sent to the physician(s) who will be following up - by name and specialty.

We look forward to working with you collaboratively on all of the components of Project RED to ensure a seamless transition for our mutual patients from the inpatient setting to a safe and healthy outpatient setting. To ensure that you have a full understanding of the program, the components of Project RED are listed below:

Components of the Re-engineered Discharge (RED) pilot program "Project RED"

1. Educate the patient about his or her diagnosis throughout the hospital stay.
2. Make appointments for clinician follow-up and post-discharge testing and
 - Make appointments with input from the patient regarding the best time and date of the appointment.
 - Coordinate appointments with physicians, testing, and other services.
 - Discuss reason for and importance of physician appointments.
 - Confirm that the patient knows where to go, has a plan about how to get to the appointment; review transportation options and other barriers to keeping these appointments.
3. Discuss with the patient any tests or studies that have been completed in the hospital and discuss who will be responsible for following up the results.
4. Organize post-discharge services.
 - Be sure patient understands the importance of such services.
 - Make appointments that the patient can keep.
 - Discuss the details about how to receive each service.
5. Confirm the Medication Plan.
 - Reconcile the discharge medication regimen with medications taken before the hospitalization.
 - Explain what medications to take, emphasizing any changes in the regimen.
 - Review each medication's purpose, how to take each medication correctly, and important side effects to watch for.
 - Be sure patient has a realistic plan about how to get the medications.
6. Reconcile the discharge plan with national guidelines and critical pathways.
7. Review the appropriate steps for a patient to take/do if a problem arises.
 - Instruct on a specific plan of how to contact the PCP (or coverage) by providing contact numbers for evenings and weekends.
 - Instruct on what constitutes an emergency and what to do in case of an emergency following discharge.
8. Expedite completion of Discharge Summary and transmission to the physicians (include other services such as the visiting nurses) accepting responsibility for the patient's care after discharge:
 - Reason for hospitalization with specific principal diagnosis
 - Significant findings (When creating this document, the original source documents – e.g. laboratory, radiology, operative reports, and medication administration records – should be in the transcriber's immediate possession and be visible when it is necessary to transcribe information from one document to another.)
 - Procedures performed and care, treatment, and services provided to the patient
 - The patient's condition at discharge
 - A comprehensive and reconciled medication list (including allergies)
 - A list of acute medical issues, tests, and studies for which confirmed results are pending at the time of discharge and require follow-up
 - Information regarding input from consultative services, including rehabilitation therapy
9. Assess the degree of understanding by asking the patient to explain in his or her own words the details of the plan.
 - May require removal of language and literacy barriers by utilizing professional interpreters/translators
 - May require contacting family members who will share in the care-giving responsibilities
10. Give the patient a written discharge plan at the time of discharge that contains:
 - Reason for hospitalization
 - Discharge medications including what medications to take, how to take them, and how to obtain the medication
 - Instructions on what to do if the patient's condition changes after discharge
 - Coordination and planning for follow-up appointments that the patient can keep
 - Coordination and planning for follow-up of tests and studies for which confirmed results are not available at the time of discharge
11. Provide telephone follow-up reinforcement of the discharge plan and problem-solving two to three days after discharge.

Your vital source of information for Health First medical quality initiatives

e-Physician

What IT can do for YOU, and what YOU can do with IT

Mobile computing revisited

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



The recent advent of small, powerful mobile computing devices such as smartphones and tablets has transformed our everyday lives. Widespread access to high-speed wireless networks enables us to use these devices to phone, text, browse the Internet, listen to music, read books, use GPS for real-time navigation, as well as download and use hundreds of thousands of “apps”.

Smartphone use by physicians

Physicians, who are often criticized for being slow to adopt new information technologies, have adopted smartphones in force. An estimated 72 percent to 94 percent of physicians now use smartphones for professional and personal use, according to an article in *American Medical News*.¹ Since medicine is mobility-centric, it's not surprising that these devices are widely used by physicians. They fit well into our workflow, which is one critical factor for successful physician adoption of any healthcare information technology. Since smartphones have limited screen real estate, they are best suited for limited, focused tasks such as reviewing drug information, clinical guidelines, or using medical calculators. Thousands of these applications are available and are often offered free or at a minimal cost and are easily downloadable via the Web.

When linked to an electronic health record, smartphones are useful to review subsets of information such as patient lists, vital signs, medication lists, and lab results. They can also be used to e-prescribe or place orders within a hospital computerized physician order entry (CPOM) system.

iPhone™ SCM app usage at HF hospitals/facilities

Allscripts, Inc., which recently merged with Eclipsys Corporation, maker of Sunrise Clinical Manager (SCM), strongly recognizes the need to support modern smartphone platforms such as the iPhone™. An iPhone™ app for

SCM has already been created and will soon be available for physicians across Health First to download onto their iPhone™ with access to common subsets of clinical information using the familiar, intuitive navigation features of the iPhone™. Below is a screenshot example.



Detail	Trend
ABG	
PCO2 torr 35-45	38
PO2 torr 80-	80
SaO2 % 90-	90
HCO3 mEq / L 22-26	25
Base Excess (BE) mmol / L 2-4	3
pH Result pH 7.35-7.45	7.4

Over time, Allscripts expects to support additional popular smartphone devices such as those running the Android™ operating system.

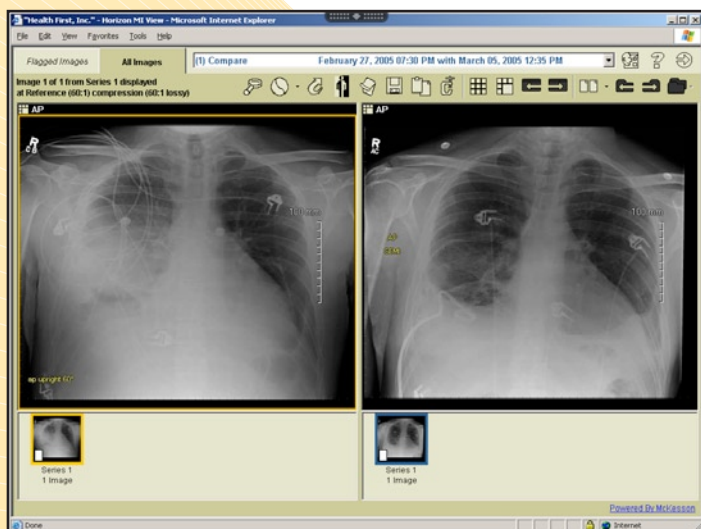
iPad™ connectivity at Health First

Earlier this year, Apple introduced the iPad™, a revolutionary tablet device that has become wildly popular, and has the potential to transform mobile computing in the healthcare arena. At 9.56” long, 7.47” wide, 0.5” deep and weighing 1.6 lbs., the iPad™ has wireless access, including 3G and a solid 10-hour battery life, is easy to carry, and has adequate screen size to navigate through a full-featured electronic health record. Since it's built on the same operating system as the iPhone™, the highly simple, elegant, and intuitive user-interface is easily recognizable to those who are familiar with the iPhone™.

My initial experience with a tablet PC was during a pilot project at HRMC using the Panasonic Toughbook™ T8 during weekend rounding in the hospital for my Internal Medicine call group. While the device was somewhat useful, my shoulders began to ache after carrying the relatively bulky device (3.3 lbs.) for about two hours, and I soon

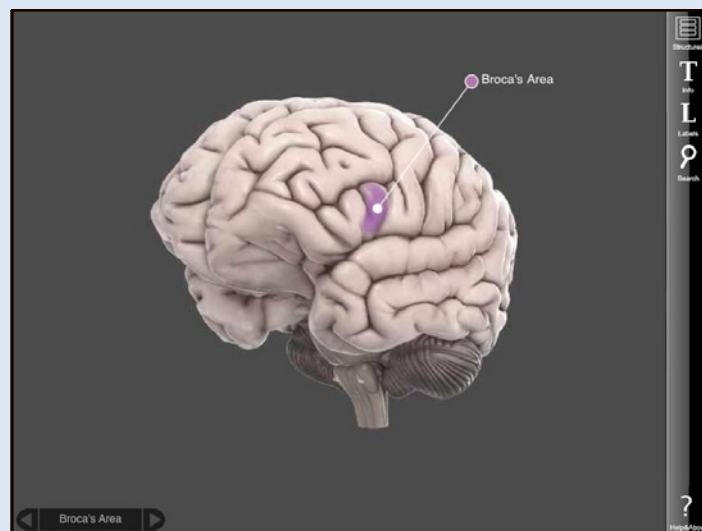
abandoned its use in favor of desktop workstations. About three months ago, however, I started using the iPad™ (via the hospital physician dedicated wireless network — ATT 3G) to access SCM via Citrix during 12-hour Hospitalist shifts at HRMC and haven't experienced any shoulder, wireless connection, or battery longevity issues. I also use it to access the Centricity™ electronic health records when seeing patients in my office practice two half-days per week. The device is fast, powerful, easy to navigate and carry, and has opened up new and exciting possibilities in the portable computing realm. The main challenge I've encountered accessing SCM and Centricity™ on the iPad™ is difficulty scrolling efficiently through documents and certain areas of these Windows™-based applications. AllScripts is planning to develop dedicated iPad™ apps to access SCM data and present it to users in the familiar iPad™-user interface, which should eliminate this problem.

I've found the iPad™ to be helpful at the bedside. For instance, patients frequently inquire about specific information pertinent to them such as recent vital signs, Lab, and Radiology results. Using the iPad™, I can quickly review that information in SCM and answer their questions without having to leave the room to access it via a fixed workstation. I also find that the iPad™ is a great patient education device. For instance, the screenshot below depicts comparison chest X-rays from a patient who had recently undergone mitral valve repair surgery and developed a post-op hemothorax, requiring placement of a pigtail chest tube. The PACS images rapidly load onto the iPad™ from SCM and can be used to show the pre- and post- chest tube placement to the patient at the bedside. The same concept can be extended to cardiac catheterization films. For instance the iPad™ could load images from the Cardiology PACS system to demonstrate coronary artery anatomy before and after stent placement.



Viewing Radiology PACS images from the iPad™

Currently there are more than 600 medical apps available for the iPad™. (iPhone™ apps can run on the iPad™, although the screen size of these apps is smaller than those designed specifically for the iPad™.) One such app, 3D Brain™, is available free for download and is a beautiful 3D rendering of human brain anatomy. The images can be resized, rotated, and labeled with simple finger gestures on the iPad™ touch screen. The screenshot below might be useful when trying to describe to a patient and their family the location of a stroke that resulted in expressive aphasia.



Several iPad™ competitors have delivered their devices to market and many more are sure to follow. In the near future, I expect we'll see even more innovative tablet devices, which will be necessary to meet the ever-increasing mobility demands of practicing physicians. Again, SCM-vendor Allscripts plans to begin writing apps for the iPad™ in the near future.

Whether on hospital rounds, in the office, home, at Starbucks®, or on the other side of the world, smartphones and tablet devices now offer anywhere/anytime access to critical information necessary for timely clinical decision-making from which physicians and patients alike are sure to benefit.

**NOTE: In an effort to assist physicians in accessing the physician-only network, Health First wants to accommodate as many personal devices as possible, with iPads™ and iPhones™ the most recent additions to the list of personal mobile devices that are supported within HF facilities. Physicians who need assistance in connecting their devices can just call extension 45000 within any HF facility to place a request for assistance.*

IT NEWS
you can use

**Order Management (OM)
HF Hospital Activation Schedule**

As the computerized entry of physician orders (called “Order Management”, or “OM”, within Health First hospitals) is rolled out throughout Health First, it’s important to understand the phased approach to this process, which will impact physicians in different ways. Watch for updates via your GroupWise™ email account and posted in physician work areas at each hospital as this process moves forward. In the first phase of the rollout at Cape Canaveral Hospital (CCH), relatively few physicians are being impacted by the electronic entry of orders, but all doctors are able to view orders electronically in Sunrise Clinical Manager.

**Phased rollout dates for other HF
hospitals:**

PBH: February 2011

Viera: April 2011

HRMC: June 2011

“

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Do a checkup on your calendar!

Calendar

December 2010

- 3** CME – Controversies in Healthcare-Associated Infection Prevention
Anthony Barile, MD and Paul Yates, HRMC (11:30 am to 1:30 pm, HRMC Auditorium)*
- 10** CME – Pediatric Trauma, Peter Pappas, MD, HRMC
(11:30 am to 1:30 pm, HRMC Auditorium)*
- 13** Special “Night at the Mandatories” 2-hour “Prevention of Medical Errors” CME Session
Cliff Rapp, LHRM, FPIC, Florida (5:30 to 7:30 pm, HRMC Auditorium)**
- 16** HRMC General Medical Staff/Department Meeting,
Department meetings at 5:30 pm, General Staff starting at 6:30 pm, Melbourne Hilton Rialto
- 17** CME not yet scheduled
- 24** Holiday weekend — no CME program
- 31** Holiday weekend — no CME program

January 2011

- 5** Special “Night at the Mandatories” 2-Hour “Domestic Violence” CME Session
Cindy Mitchell, Salvation Army (5:30 to 7:30 pm, HRMC Auditorium)**
- 18** CCH General Medical Staff Meeting
6:30 pm, CCH Medical Plaza Conference Rooms
- 19** Special “Night at the Mandatories” 2-hour “Prevention of Medical Errors” CME Session
Cliff Rapp, LHRM, FPIC, Florida (5:30 to 7:30 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 for “Night at the Mandatories” sessions **only: Sessions will be simultaneously video-conferenced into the PBH Private Dining Room and CCH Medical Plaza Conference Room B. A light snack will be served at HRMC beginning at 5 pm, and dinner will be served at PBH starting at 5:30 pm. Also for “Night at the Mandatories” sessions only, please fax your reservation to the Medical Staff Office at the site where you’ll be attending the session (see fax numbers below) and note your full name, title and date of session you wish to attend. For more information or forms you can call **Dee Rogers at 434-1966**. Medical Staff Office fax numbers for locations of “Night at the Mandatories” are:

CCH: 799-8477

HRMC: 434-5244

PBH: 434-8089