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AHC Media

Protecting non-physician peer review

Check your state laws: Only doctors may have protection

Florida has joined a rarified group of states that provide no protection for any documents produced as part of peer review for non-physician providers. Florida joined Kentucky and a few other states as one where healthcare professionals who try to learn from mistakes are at risk of any written materials from peer review being subject to discovery by lawyers during litigation.

Amendment 7, which made all documents related to provider performance discoverable, has been through just about all the litigation it can be regarding its constitutionality and according to **Vanessa Reynolds**, of counsel at Broad and Cassel in Ft. Lauderdale, FL, is likely to stand as is for the foreseeable future.

The history of Amendment 7 goes back to 2004, when two amendments to the constitution were put before Florida's voters — one that would allow information on adverse events to be available to the public, and one limiting the compensation that trial lawyers could collect. The thought was that if the compensation was minimized, there would be less litigation, and thus the discoverability of adverse events from peer review documents wouldn't matter. Appeals on the first measure led to lawyers and clients being able to waive the limit on fees, thus effectively subverting the measure. Amendment 7, though? It stands, and after a lot of litigation, looks as though it will continue to do so. Marketed as the "Patients' Right To Know" amendment, chances of revoking the amendment would be slim even if there wasn't a wider move afoot toward transparency and making more data available to patients, she adds.

"We stand nearly alone in the U.S. in having no peer review privilege," Reynolds says of Florida. "Only attorney work product is privileged, and everything that hospitals have tried to protect documents they generate has been struck down by the courts." Documents that reflect the impression of an attorney preparing a case for anticipated or actual litigation are safe, she adds. "The danger is that you turn peer review into a pre-litigation process, when that isn't the purpose of it."

Hospitals have tried limiting the kinds of documents they generate — producing enough to review the quality of work done, but not so much that

they reveal potentially damaging information. "It's an extremely fine line," says Reynolds. "And you will find as many different opinions about what that line looks like as there are lawyers and healthcare providers."

Other states have other rules. In Illinois, the Medical Studies Act allows protection for any provider depending on the activity involved, says **Mike Callahan,** a partner at Katten Muchin Rosenman in Chicago. "It applies to data, reports, analyses, meetings, and materials when it relates to reducing morbidity and mortality and improving patient care," Callahan says. "By its very definition, it isn't limited to only physicians."

The glitch in Illinois and states like it is that if a discussion takes place between a nurse as an employee and someone in human resources as the employer, that isn't protected. If you want a discussion to remain confidential, it has to be within the confines of the statute, he says. "It doesn't mean you can't have conversations in the realm of HR, but you have to know that what you produce from those discussions is at risk. Hospitals forget that these discussions between employer and employee may not be captured under state confidentiality rules."

Callahan says Illinois may have more protections than many states for the kinds of providers protected. But it also has fewer in that it only applies to hospitals and managed care entities, not nursing homes, physician or other provider groups.

Nationally, the 2005 Patient Protection and Quality Improvement Act allows for protections in groups that are part of patient safety organizations (PSOs). "The protections under the act are that if you contract with a PSO, every licensed provider in your hospital is protected," he says.

Even those rules are still being figured out, though. Callahan is working on a case involving Walgreens, which set up a PSO in 2009. The company does a lot of internal tracking of outcomes and medical errors, and collects the data within its patient safety evaluation system. The company was subpoenaed in 2010 by the Illinois Department of Financial and Professional Regulation, which covers licensing of physicians, nurses and other providers. Walgreens was asked to turn over some medication error incident report data related to three pharmacists. Walgreens argued that pursuant to the act, the records were not subject to discovery. The state sued, Walgreens countersued to have the action dismissed and the company won. It is now before the appellate courts.

In California, both those who conduct reviews and those who are being reviewed in peer review have legal protection from discovery, says **Mark A. Kadzielski,** a partner at Fulbright & Jaworski in Los Angeles. However, this only applies to those

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who are legally required to be part of a peer review process. Nurses, unless they are advanced practice nurses who have been granted privileges to practice at the hospital, are not protected because they are not required to be part of a peer review system. "In that case, it's a human resources function to review the work," Kadzielski says. And just like in Illinois, what happens in HR is discoverable.

In Texas, however, there is a very robust nursing peer review process that is required under the Texas occupation code. Law there protects the work of those peer review sessions from liability and discoverability, says Kadzielski.

"My mantra is that you have to have memorized your state statute and the case law surrounding it," Callahan says. His page on the company website (http://www.kattenlaw.com/callahan/) has a variety of links, articles, and presentations that can help those in various states understand the various rules better.

"No one will understand the scope of protections unless you get risk managers, quality directors, the in-house attorney and administration all sitting at the table and going over it," he says. "Most risk managers in this state think most of what they generate isn't protected. A year ago, when I gave a presentation about PSOs, they didn't know that they offer protection, and they should have."

The Agency for Healthcare Research and Quality (AHRQ) has a PSO website (http://www.pso.ahrq.gov/) that provides a wealth of information on the topic, Callahan adds.

Ultimately, Reynolds believes that if you want peer review to be meaningful, "it has to leave you exposed to litigation." That doesn't mean that a hospital should leave it all hanging out. Rather, it means they should continue to perform peer review in a sensible manner that leads to better care and fewer errors. "Do everything you did before, but think about the documents you generate," Reynolds says. "Everyone should do that anyway."

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Survey Field Report: Sending out an SOS

How four rooms in the middle of a hospital made a summer of surveys go more smoothly

It was a "perfect storm," says **Paula Swain**, director of accreditation and regulatory for Novant Health/Presbyterian Healthcare in Charlotte, NC. In the first week of June, it became clear that between mid-July and August 20 there would be both Joint Commission and Centers for Medicare & Medicaid Services (CMS) surveyors on the grounds of 607-bed Presbyterian Hospital in Charlotte, potentially at the same time. It's the kind of realization that can make one's heart skip a beat.

But there wasn't time for beat-skipping. Swain and her colleagues had to figure out a good way to get through a difficult situation without panic and with an eye always on the ball of quality, safety, and success.

That Swain is still talking — raving — about how her team performed is a testament to hard work, a degree of luck, and some serendipitous decision-making.

Indeed, just tweaking the way they physically arrange for survey made a huge difference.

Serendipitous event number one: Leadership had all participated in Hospital Incident Command Systems (HICS) training, emphasizing the benefits of having a command center for big events. "We applied that training to what we called the War," Swain says. The hospital also had to undergo biannual health department visits where two teams came, one starting at the top of the hospital, one at the bottom. They'd eventually meet in the middle. "We figured if we were in the middle vertically and horizontally, it would be easier."

Serendipitous event number two: They had just opened a new public safety wing in the dead center of the hospital. Setting up a suite of those rooms as a command center seemed like a great idea. Each room would have a function, a staff, and appropriate supplies. *(For a list of rooms and functions, see box page 112.)* All would be linked with a conference line that was kept constantly open so that all interested parties could keep track of where surveyors were, what they were looking at, and whether there was anything they found that needed to be printed, fixed, or located.

The public safety classroom was used for check-in; the command center room was used for monitoring communications and ensuring tasks were complete; the squad room was used to dispatch people to fix problems as they were found; and the review room was used for document management. The nursing classroom down the hall was used for the surveyors to check in, hang out, and meet their escorts.

When a surveyor, out with a scribe and escort, found issues with a room, the call was dispatched through the command center and the task was picked up by staff in the squad room. Often, before a surveyor even left a room, whatever issue they found — a stained ceiling tile or broken switch —was in the process of being fixed by staff who seemed to be able to read minds. "When they pointed, someone with a ladder would appear," says Swain. If a particular kind of patient chart was required, then the staff in the review room would find it, print it, and take it to the command center for review to ensure the file was complete. If it wasn't, whatever it was missing was found. Then and only then was it sent on its way.

Everyone was in a central location. Previously, Swain says they used a single conference room with a long table. There was a crowd, a noise level, and a panicked busy-ness that made getting done what had to get done hard. Three people might hear something was needed and all would get up to do it. Under the new system, the people in charge of the labor pool would dispatch a single person.

A little shifting, but little hassle

The new wing was designed to have this command center structure, Swain says. There was a door into the command center, and a door from that room into the public safety office and the squad room. The people who usually used the squad room to get their coffee and go over their files were imposed upon, and classes that were planned for the public safety office were cancelled or moved. But aside from that, no staff were shoved out of the way or made to double or triple up to make room for the new arrangements.

Further, the four-room setup with designated people in specific roles meant that no extra staff had to be called in. Swain says Novant Health offered to send assistance for education and scribing.

In the old system, there was a rolling cart with phones, computers, printers and other equipment that was brought into the conference room for the masses to fight over. In June, when a small group of surveyors from the state were on site, they would ask for documents or charts. "I kept looking for staplers and tape and could never find it," recalls Swain. Now, each of the four rooms has its own box of general office supplies.

What had been like an ant hill kicked by a careless walker was now orderly and fairly seamless. Part of that was because of regular mock survey drills Presbyterian held. At these, sweepers would come in at 7 a.m. They were assigned by unit to check rooms, find the best charts, and ensure that anything missing — signatures, dates — was completed. They would call in any needed work and

Work room descriptions — Summer of Surveys

Public Safety Classroom
Purpose:
• Check in for all roles.
• Conference Line Control Station to:
Facilitate, record, dispatch
Support volunteer staff
Create workstations for problem solving

Command Center
Purpose:
• Manage communication flow,
• Make assignments,
• Assure all sites reviewed
• Review scribe notes, conference calls from recorder and track issues to completion
• Close loops

Squad Room
Purpose:
• Place for service line experts (hospital operations leads)
• Act on issues referred to it
• Place for scribe/escort teams to join surveyors

Review Room
Purpose:
• Document management
• Run document to surveyor room after approvals
• Type scribe notes

Nursing Classroom
Purpose:
• Surveyors' comfort
• Keep hospital staff linked to surveyors
• Provide material check in

follow up on those orders. "It was real-time communication and practice," says Swain. These drills lasted just an hour, but they paid dividends. "We'll never change this. People go to their posts and know what to do."

Next month, *HPR* will look at some of the direct results of the Joint Commission survey at Presbyterian Hospital, and the lessons learned.

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Simulating your way to success

From CPR dummies to a Sims game

If lucky, the typical obstetrician sees a postpartum hemorrhage just a handful of times in his or her career. The problem is that the rarity makes it hard to prepare for the emergency. And even if the doctor is ready, will the team around the doctor know what to do without experience? You can read about what to do all you want, but just as your piano teacher told you, practice makes perfect. For a small obstetric and med/surg hospital, such as the 30-bed Sutter Maternity and Surgery Center in Santa Cruz, CA, drills using actors as patients seemed the best way to prepare. But they are imperfect, says **Betsy Stone**, MPH, DrPH, director of quality and patient safety for the Palo Alto Medical Foundation, which runs the facility.

The hospital is half perinatal, and half med/surg. There is no emergency department, and no ICU. If there is a bad outcome, the patients are transferred to Dominican Hospital, about a mile down the road. "Having people to pretend to be patients is just not the same as seeing the events unfold and cascade downhill," she says.

Lucky for Sutter, Cabrillo College, the local community college in nearby Aptos, has a nursing program that includes a simulation lab. One of the instructors is a nurse at Sutter, and she helped put together a program to do patient safety training drills with the Sutter staff at the college. The first drills, on issues such as coding patients and perinatal hemorrhaging, were in August. The hospital provided its own equipment so that staff would be working in a situation as close to that which might occur in their facility as possible. The sessions were taped, and the dummies were programmed for a progressive drill where a series of events showed the patient decompensating. The goal, Stone says, was to improve teamwork, collaboration, and communication.

In each drill, primary nurses started, with additional nurses coming in as the situation mandated and as they were called. For instance, a single nurse would do a hand-off to her successor for a patient. The new nurse would listen to the dummy's chest and perhaps hear some crackles in its "lungs." The "patient," however, would report feeling fine. What happens next?

Two obstetricians were also present for the perinatal drills, and other scenarios that include physicians are being considered. "These were learning situations, not punitive, and people were really excited to participate." Eventually, all the nurses at the facility will probably go through the drills.

What to start with was based on things that had either happened at the hospital or that keep staff up at night worrying they might happen, Stone says. "Sim labs help students learn to nurse, and it's the next best thing to using real patients. If you see something every five years, will you catch it after two minutes, when you might make a difference, or after 15, when you can't?"

If the hospital expands to include an ED or ICU, the ability to pair with a local simulation lab to work on issues like triaging will prove helpful. And she thinks it's a "gift" to give to staff to show them that in a fast-paced situation, they have the skills they need to make a difference. Reacting to an actor is different from reacting to real-looking data from a computer. An actor can't change his blood pressure; you can't pound on an actor's chest.

Sutter shared some costs with the lab, used its own supplies, and had to pay for the staff to attend the training. There was also a fee to use the lab. "But it was totally worth it," says Stone.

Expanding reach

While more facilities understand the value of simulation in improving patient safety, it's still not used everywhere it could be, or everywhere it will be, says **Jeffrey Cooper**, Ph.D., executive director of the Center for Medical Simulation at Harvard Medical School. Part of that is the worry about associated costs. But there are ways around that

argument.

For instance, at Massachusetts General Hospital, anesthesiologists and some surgeons who go through a simulation training program get a break on their malpractice fees, he says.

And you don't have to build a whole simulation lab to use simulation dummies, says Cooper. You can use empty rooms. As for up-front costs, he notes that donors often like the idea of springing for such novel and potentially useful equipment. Training costs money, but there are grants.

"You don't know when you will have a fire or a disaster, but you train for that," Cooper says. "You are required to. But there is no requirement to train for clinical disaster." The costs associated with such dramatic adverse events can be astronomical. "But simulation as a training technique helps you learn to work together to prevent such catastrophic errors and harm to healthy people." Those are the cases that make headlines, Cooper says. It seems like an easy calculation for even the most cost-averse organization to make that working simulation into patient safety training is a good idea.

But it isn't just those exciting, sexy applications of simulation that matter. How to do basic infection control — things you have to practice until they become rote and that you don't necessarily want to practice on real patients — is a good use for mannequins, says Cooper. Another good one is to practice emergency procedures. "Not codes, but other kinds of emergency protocols. Pilots don't memorize what to do if an engine fails. They work in simulation, practice, train, and then do. Healthcare can do that, too, for all sorts of emergencies."

Usually, it takes one of those news-making bad events to get people on board with simulation. "Don't wait for that," Cooper says.

Coming down the pipeline is a new form of simulation that probably has more in common with your children's Sims computer game than a CPR dummy. It could be one of the most useful tools yet, says **Jeff Terry**, FACHE, managing principal of clinical operations for GE Performance Solutions.

Computer program models of a facility are created with a great level of detail. How many beds are filled and the number of transfers you expect; the times of your expected supply deliveries and how that might change if it snows; how many patients you have on the third Sunday in October — all of that is included. Using these models, you can change variables to see how your facility overall will perform. So if you have a busy winter Monday morning — because Mondays are always busier than Tuesdays — but three of your nurses come down with a cold, what will happen? How will your facility react if there is an outbreak of swine flu? What happens if your expected delivery of surgical supplies is a day late?

Terry says that knowing how many transfers you usually get on a Monday, with what acuity, and considering your existing patient census will allow you to staff appropriately.

Instead of practicing a procedure on a mannequin, you are simulating processes of care on a computer, Terry says.

The primary users of these newfangled simulation programs are primarily the bed desks, but the data they provide are helping QI staff, too. "There is a lot of capacity strategy in this at the start," he says. "But then you develop the QI and safety strategies to deal with your capacity. If three cardiologists leave, what do you do? If a hurricane hits, what happens?"

"Let's pretend" used to be a game for children. But dolls and computer game substitutes can be considered tools in the healthcare workplace of the future, too.

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Additional Resources

• Center for Medical Simulations: http://www.harvardmedsim.org/

• Society for Simulation in Healthcare: http://www.ssih.org/Home/

• Simulation Center Directory: http://www.ssih.org/resources/simcenterdirectory/

• Center for Integration of Medicine and Innovative Technology: http://www.cimit.org/

• International Nursing Association for Clinical Nursing Simulation: http://www.inacsl.org/INACSL_2010/

• Bristol (UK) Simulation Center Sim Center

Database: http://www.bmsc.co.uk/sim_database/centres_europe.htm ■

NQF draft reports: A light at the end of the tunnel?

Will measurement requirements finally decline?

There are hundreds of data measurements that hospitals and healthcare providers are required to submit to a variety of government and regulatory agencies. They are often repetitive exercises, but usually not enough so that what you do for one organization can be sent on to another one as well. The requirements take time, money, multiple systems, and cause a lot of frustration. But could the end be in sight?

Two new draft reports from the National Quality Forum (NQF) might lead to a consolidation of requirements and the creation of an "ideal data set" that would work for multiple organizations, preferably using a single reporting system.

The Measurement Applications Partnership, comprised of providers, payers, regulators, and others, released the two reports for public comment in August. Comment closed in mid-September, and interim reports are due for release by the beginning of October when more comment will be solicited.

The Clinician Performance Measurement Coordination Strategy (http://www.qualityforum.org/Setting_Priorities/Partnership/Clinician_Workgroup.aspx) is supposed to align measures and data sources, create an ideal measure set, define data platform principles, and determine a pathway for improving measure application. It also includes a draft version of the selection criteria used to assess measure sets.

The second draft report is the Coordination Strategy for Healthcare-Acquired Conditions and Readmissions across Public and Private Payers (http://www.qualityforum.org/Setting_Priorities/Partnership/Ad_Hoc_Safety_Workgroup.aspx).

The focus in the second report is on reducing nine hospital-acquired conditions: adverse drug events (ADE); catheter-associated urinary tract infections (CAUTI); central line-associated blood stream infections (CLABSI); injuries from falls and immobility; obstetrical adverse events; pressure ulcers; surgical-site infections; venous thromboembolism (VTE); and ventilator-associated pneumonia (VAP). It identifies three focus areas for aligning public and private efforts to reduce healthcare-acquired conditions and readmissions: measures, data, and coordination strategies.

The draft report calls for consistent measures that allow for valid comparisons and which are not onerous to providers. They should apply to patients regardless of payer and across all healthcare settings. The data should also be "clear, meaningful, and readily available," to consumers and payers alike, according to the draft.

Harmonizing reporting processes for government entities like AHRQ, CMS, and the CDC is mooted as a way to decrease the burden on providers, and safe care should be rewarded.

While both of these reports have the potential to make things easier for providers and those who manage quality data, some worry that the focus won't be on all the things that need attention. **Felisha Bochantin**, a senior coding analyst at Optum Insight in Ashley, IL, says that the things that worry her are the things that aren't reported. "If it isn't documented, it didn't happen," she says, and figuring out any ideal measure set still involves only the things that you actively measure. "What about near misses? You can talk all day long about data sources and data mining, but if it isn't reported, it didn't happen."

Still, defining quality measures is a big step, Bochantin says. And while what applies to one hospital might not apply to another, there are some truths that apply to all. Figuring out what they are is a capital-G good thing.

The length of time and the degree of difficulty in getting all of the different parties to sit down, agree to data sets, and potentially give up their own little fiefdoms of power will be considerable. The timelines on both of these reports stretch out almost a year before final editions are due to be released.

In the meantime, quality professionals should keep on top of the measures that are being promoted by major groups, and be involved with internal health IT initiatives so that you can ensure your systems can capture whatever data are necessary. "Quality professionals can't anticipate every possible data element that might be needed to satisfy the measurement demands of external groups. However, we can be involved in our organization's IT implementation plan," says **Patrice L. Spath**, MA, RHIT, a consultant in health care quality and resource management with Brown-Spath & Associates in Forest Grove, OR. "You need to get

your input heard so your facilitywide information system is capable of gathering measurement data for today's requirements and sufficiently flexible to meet those in the future." When selecting IT systems, the potential for gathering reliable performance measurement data should be one of the considerations.

Another issue to consider moving forward is standardizing definitions between various providers, says Spath. "For instance, if a patient leaves the hospital and develops an infection, you have to be sure that what the physician in the office thinks is a hospital-acquired infection matches your definition. It may be classified as a nosocomial infection, even if they suspect it is."

The hope is that the work of NQF and its task groups will reduce duplication of data collection, Spath says. "But there is still a high likelihood that costs associated with performance measurement activities will continue to rise. That's why quality professionals must constantly seek more efficient ways of gathering data and analyzing results."

And just to show that the more things change the more they stay the same, within two weeks of the release of the draft reports that many hope will lead to less measure mayhem, the NQF endorsed 10 measures on end-stage renal failure and one on CT radiation.

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Study eyes EOL trends for Medicare patients

Findings indicate more time spent in the ICU

A new study from the Dartmouth Atlas Project seems to indicate the "report card" for Medicare patients at the end of life (EOL) is a mixed bag of pluses and minuses.

On the positive side, the study, "Trends and variations in end-of-life care for Medicare beneficiaries with severe chronic illness," showed that Medicare beneficiaries with severe chronic illness spent fewer days in the hospital at the end of life in 2007 than they did in 2003, and they were less likely to die in a hospital and more likely to receive hospice care. On the other hand, they were more likely to be treated by 10 or more doctors in the last six months of life in 2007 (36.1%) than they were in 2003 (30.8%), and the average number of days in the intensive care unit (ICU) increased to 3.8 from 3.5.

"The fact that these patients are spending less time in the hospital is connected with the fact that they are spending more time in hospice," notes lead author **David Goodman,** MD, MS, the co-principal investigator of Dartmouth Atlas of Health Care, professor of pediatrics and of health policy, and director, Center for Health Policy Research, at the Dartmouth Institute for Health Policy and Clinical Practice, Lebanon, NH. "But the fact remains that these are the two domains where patients receive higher-intensity care, and there were more ICU days. And it's not just the ones left in the hospital who are sicker patients; there are more numbers of ICU days across the entire population of those who died, so there is a real increase of ICU care in this population. Patients certainly spend less time on general hospital wards, but they spend more time on the ICU."

Goodman says the medical profession is uncertain as to the reason for this situation and adds, "This is not true for every hospital. It's fascinating that there are some hospitals where their change is in parallel with this study, while others have defied this general trend."

In other words, he says, it is not the "destiny" of any specific facility to have these patients spend more time in the ICU. "I think one of the important factors that tend to shape the local experience is how local healthcare systems invest and what they invest in," says Goodman. "Places that make relatively greater investment into ICU units can be providing valuable care for certain patients, but they can have unintended consequences as well."

Trends must be reversed

Goodman says that for things to improve in hospitals, health systems and providers must "unlearn" certain assumptions. "In places that have grown their population of physicians and subspecialists, that is the capacity that gets used," he explains.

"I am a trained physician," he continues. "The classic way we think of ourselves is that our job is to gather as much information as we can about the patient and their condition. We have knowledge of treatments, we learn about the patient's condition, and we make a recommendation."

But that common role of making recommendations does not work today, says Goodman, and it won't in the future, particularly for very sick patients. "It assumes we understand all of the care options, and often we don't," he says. "Oncologists, for example, are very much focused on curative care, but they won't be experts on palliative care. They may not understand what the patients' values are; studies have shown that doctors often use their own value sets. That approach is well-intentioned, but it misses the mark."

What's more, there is no correlation between intensity of care and measures of technical quality, Goodman continues. "When you spend many more days in a hospital ICU, you see many different doctors, but the quality of care tends to be lower," he says. "We think that's because care becomes disordered. There are more handoffs, and more chances for missed communication."

In addition, he says, electronic medical records (EMRs) do not solve that problem. "EMRs rarely extend to full care, especially in chronic care facilities," Goodman says.

Reduce spending, improve quality

Risa Lavizzo-Mourey, MD, MBA, president and CEO of the Robert Wood Johnson Foundation, a long-time funder of the Dartmouth Atlas Project said that another implication of the study's findings is that "providers can look for insights into potential savings they can achieve through improved care of chronic illness that allows patients to remain safely out of the hospital." Lavizzo-Mourey released the statement to accompany the study's publication.

Goodman agrees. "We shouldn't be surprised we're spending more money on healthcare than any other developed country in the world, but there might be opportunities to do a better job with less money, particularly when some patients get expensive care they do not want," he says. "There are opportunities for accomplishing greater efficiencies thoughtfully. I'm not talking surgery with dull tools, but crafting our models of care and reimbursements so we can deliver higher quality for less cost."

End-of-life care is one place where we know if patients get palliative care services early in the care of chronic illness, they have a much better experience, he says. "They generally have a lower intensity of care, which saves money, and at least in cancer care, there are studies that show they actually live longer," says Goodman.

For additional information, contact:

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TJC issues alert on diagnostic imaging

The message from the Joint Commission's latest Sentinel Event Alert is clear: reduce radiation exposure from diagnostic procedures.

Over the last 20 years, the typical American has seen exposure to ionizing radiation double. Most of the time, patients are sent for imaging without the prescribing physician having any idea of how much other radiation the patient has been exposed to. Meanwhile, recent studies have increased concerns about the potential health risks associated with too much radiation, particularly in certain populations, like children.

Joint Commission President **Mark Chassin**, MD, FACP, MPP, MPH, says that there isn't a lot of consensus on how much is too much, and in what time frame. It's prudent, then, to develop strategies to ensure patients get the right imaging with the lowest possible exposure to radiation.

The latest alert makes the following suggestions:

• Using imaging techniques other than CT, such as ultrasound or magnetic resonance imaging (MRI), and more collaboration between radiologists and referring physicians about the appropriate use of diagnostic imaging.

• Adherence to the Nuclear Regulatory Commission's ALARA ("as low as reasonably achievable") guidelines, as well as guidelines from the Society of Pediatric Radiology, American College of Radiology, and the Radiological Society of North America for imaging for children and adults, respectively.

• Assurance by radiologists that the proper dosing protocol is in place for the patient being treated and review of all dosing protocols against

the latest evidence either annually or every two years.

• Expand the radiation safety officer's role to explicitly include patient safety as it relates to radiation and dosing, as well as education on proper dosing and equipment usage for all physicians and technologists who prescribe diagnostic radiation or use diagnostic radiation equipment.

• Implement centralized quality and safety performance monitoring of all diagnostic imaging equipment that may emit high amounts of radiation cumulatively.

More information is available at the Joint Commission website, www.jointcommission.com. ■

A high-tech approach to medication reconciliation

Data flow directly into the EHR

There is no question that hospitals face innumerable challenges in meeting the "meaningful use" of health information technology (HIT) criteria established by the Health Information Technology for Economic and Clinical Health (HITECH) Act in 2009. However, it is also becoming clear that among the first to benefit from HIT enhancements are hospital EDs, where the ability to access patient information quickly can be especially important.

The ED at Inova Alexandria Hospital in Alexandria,VA, is a case in point. With the touch of an icon, clinicians here can quickly find out what prescriptions a patient is taking, regardless of where in the country these prescriptions were filled, explains **Martin Brown**, MD, FACEP, chairman of the Department of Emergency Medicine at Inova Alexandria Hospital. This capability is part of a pilot program involving the Northern Virginia Regional Health Information Organization (NoVaRHIO), the non-profit group established in 2007 to facilitate the electronic exchange of health information for providers in northern Virginia. However, project administrators say the idea is to eventually expand this capability to all providers in the region, and to extend the information-sharing capacity to include laboratory results, radiologic studies, and other health information as well. Experts say the pilot offers an early glimpse of efficiencies and safeguards that will be possible when the nation's health care infrastructure has been completely wired.

While NoVaRHIO operates in the interests of all the region's hospitals, physicians, and residents, it was clear early on that Inova Alexandria Hospital was best suited to be the pilot site for this project, says Brown. "NoVaRHIO needed a pretty big site that was willing to participate," he says. "It was a risk [for the hospital] in terms of time commitment and operational complexity, but it was worth taking that risk given the potential benefits."

The considerable groundwork for the project was completed by IT consultants, who worked with NoVaRHIO and the hospital's IT department before clinicians were ever involved, says Brown. This phase of the project involved creating the IT tools needed to get different databases to communicate with each other. However, Brown points out that the system is still being tweaked to operate more efficiently.

"What is unique about this project is that we are completely integrating [the pharmacy data] into the electronic health record at Inova Health Systems," explains **Edmond Magny**, PMP, an HIT expert who is managing the project for NoVaRHIO. When a query for a patient's medication history is made to the system, the information flows directly into the health record for the physician to consume, he adds.

"It allows physicians to stay within their native electronic health record as opposed to going to a different portal or going through several steps," he says. "Physicians are very keen to do exactly what they are trained to do, and not having to do 15 steps in order to get somewhere, so making sure it fits into their workflow is absolutely critical."

For this kind of seamless information sharing to take place, information coming into the hospital from a pharmacy benefit manager [PBM] must be transformed into a continuity of care document (CCD), a standard type of document that any certified electronic health record must be able to accept, explains Magny. And this is the critical step that the health information organization provides.

While the IT aspects of the project are complex, clinicians have found the tool to be user-friendly. "It took just a few minutes to show physicians and physician assistants how to use the system," says Brown. "For nurses, it is just a little bit more complicated because they are responsible for documenting the medications, but it is still very simple."

Since the approach is still a pilot, the hospital decided to ask patients for their consent before querying the IT system for the patient's medication history, says Brown. This takes place right at registration, and thus far, 80% to 90% of patients have agreed to the search, and the rest of the patients

probably just don't understand what they are being asked, he says.

It takes a few minutes for the pharmacy record to feed into the hospital's electronic medical record, but "by the time I pick up the patient in the back, there is something for me to click on that will show me what was sent from the [PBM]," says Brown. "The patient might have filled a prescription in Los Angeles three days ago or filled it around the corner two months ago, but it will show up there."

A nurse or physician always confirms with the patient that he or she is taking the indicated medications, but the hospital has found the information to be accurate in every case thus far, says Brown. And there have been some instances where the information may have prevented serious adverse events.

For example, Brown recalls the case of a woman who came into the ED and provided the nurse with information about what medications she was taking, but when the nurse clicked on the icon for the medication history information, she learned that woman was taking Coumadin, a blood thinner that is known to interact with many medications. The woman forgot to mention that she was taking Coumadin.

"Patients may know some or most of the medications they are on, but they don't always know which ones are important, and they can forget the important ones," says Brown. "That has happened more than once."

The capability is also valuable in instances where elderly or chronically ill patients who take several medications come into the ED and aren't sure of the specific names of all of their medications. The ED at Inova Alexandria hospital isn't a trauma center, but Magny points out how helpful this information would be in cases where the patient is incapacitated.

"If the patient is unconscious and came via ambulance, and all you have is the driver's license in his wallet, how is the doctor going to know if the patient is taking anticoagulants, antibiotics, or anything else?" says Magny. "You really don't know, so you are taking a guess, and medication errors are one of the biggest causes of adverse events in a hospital."

COMING IN FUTURE MONTHS

- More survey field reports
- Measurement basics
- The latest standards from NQF
- Can peer review be reformed?

CNE QUESTIONS

1. Nurses in which state have protected peer review?
   a. Florida
   b. Texas
   c. Tennessee
   d. Kentucky

2. Simulation programs at Mt. Sinai Hospital brought in how much new annual revenue?
   a. $15 million
   b. $12 million
   c. $120 million
   d. seven figures

3. Using a command center structure at Presbyterian Hospital involved
   a. using a nursing classroom
   b. moving public safety staff out of their office
   c. cancelling some classes
   d. all of the above

4. According to **Edmond Magny**, PMP, for pharmacy information to automatically populate an electronic health record, this information must first be:
   a. cleared through the hospital's security system.
   b. screened for inaccuracies.
   c. transformed into a continuity of care document (CCD), a standard type of document that any certified electronic health record must be able to accept.
   d. previewed by clinicians.

CNE OBJECTIVES

Upon completion of this educational activity, participants should be able to:

- Identify a particular clinical, legal, or educational issue related to quality improvement and performance outcomes.
- Describe how clinical, legal, or educational issues related to quality improvement and performance outcomes affect nurses, health care workers, hospitals, or the health care industry in general.
- Cite solutions to the problems associated with quality improvement and performance outcomes based on guidelines from relevant authorities and/or independent recommendations from clinicians at individual institutions.

At press time, the medication history pilot at Inova Alexandria still had a few more months remaining, and technical glitches were still being worked out, according to Brown. But he anticipates that the approach will become routine practice in the ED.

"We think this kind of system will improve the safety of our medication practices in this department," says Brown. "We haven't proved that yet. It is still too early in the game to say we have proof that is the case, but it seems intuitive and logical that if this information is proven out to be consistent and reliable, that our medication use in the ED and our diagnostic and treatment decisions in the ED will be inherently safer based on the information we have early in the visit."

As health information exchanges (HIEs) continue to develop, Magny says hospitals will be able to further leverage their functionality and the value that HIEs provide. "Every state has at least submitted plans for an HIE. Not every state has one yet, but in the future, every state will have an HIE, if not multiple HIEs." ■

Note: In the August 2011 issue of *HPR*, Philip Vaidyan's name was misspelled. He is practice group leader for IPC The Hospitalist Company.

CNE INSTRUCTIONS

Nurses participate in this CNE/ CME program and earn credit for this activity by following these instructions.

1. Read and study the activity, using the provided references for further research.
2. Log on to **www.cmecity.com** to take a post-test; tests can be taken after each issue or collectively at the end of the semester. *First-time users will have to register on the site using the 8-digit subscriber number printed on their mailing label, invoice or renewal notice.*
3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.
4. After successfully completing the last test of the semester, your browser will be automatically directed to the activity evaluation form, which you will submit online.
5. Once the completed evaluation is received, a credit letter will be e-mailed to you instantly. ■