Survey IDs Most Wired, Wireless Hospitals

BY NASEEM S. MILLER

Gone are the large white boards at the emergency room of Inova Fair Oaks Hospital in Fairfax, Va. Two large flat-screen computer monitors have taken their place. The patient information displayed on the screens is constantly updated through small tablets cradled in the arms of physicians and nurses.

If you ask the emergency department staff, they will tell you they can't imagine having to go back to paper.

Going from paper to the electronic system wasn't an overnight process. It took time. It took training. And it cost money. But it has paid off by improving efficiency, quality, and throughput, say officials at Inova Health System, of which Inova Fair Oaks is a part.

The health system was named as one of the most wired hospitals in the nation by Hospitals & Health Networks' annual most wired survey.

The 99 hospitals and health systems that made the unranked list were recognized in the categories of most improved, most wired, most wireless, and most wired in small and rural settings.

The list is the result of 555 submitted surveys, which were filled out voluntarily by the institutions and represent 1,280 hospitals (22% of U.S. hospitals). The survey, conducted since 1999, aims to benchmark hospitals' progress in information technology. The hospitals were recognized for achievement of IT applications in the areas of clinical quality and safety, care continuum, infrastructure, and business and administrative management.

The 2010 survey shows, for example, that the most wired hospitals are further along (82%) than other hospitals (51%) in deploying computerized provider order entry (CPOE) systems.

Under the Health Information Technology for Economic and Clinical Health Act, hospitals are incentivized to use electronic health record (EHR) systems in a meaningful way with financial bonuses through 2016. Yet, experts say that much more work needs to be done before the majority of hospitals will achieve the HITECH goal by then.

When hospitals do comply, however, the benefits are great on the practice side, according to Geoff Brown, Inova Health System's chief information officer. Implementing the right electronic systems can help improve quality of care and efficiency at the hospitals, he said.

The HITECH incentives 'say you've got to figure out a way to do it, and if you do it, you might get a few carrots. They haven't made a good business case for hospitals to do this.'

This is especially true for hospitalists, who tend to care for a variety of patients. Having to view the patients' information and status quickly can be laborious on paper. An electronic system that displays the patient history, allergies, and medications can be a lot more helpful, he said.

So what does it mean to be an ideal wired hospital?

Dr. Franklin Michota, director of academic affairs in the hospital medicine department of the Cleveland Clinic, said that it starts from a patient-focused perspective: electronic medical records that are available to everyone who sees the patient, information that a patient can access, patients' ability to log their diet and exercise in a system, and patients' ability to communicate with their health care provider.

In other words, "all information, all vital signs, all notes, and all orders are paperless," Dr. Michota said. And for a truly efficient hospital, that system is integrated with billing, supply chain, and other systems such as the regulatory requirements.

But the nation's health care systems and providers—big and small—have a long way to go before achieving that ideal, said Dr. Michota.

While the financial sector has long had online banking and national and international access to ATMs, hospitals in the same city are still unable to connect with each other, much less connect to hospitals and doctors' offices elsewhere in their state or across the nation.

That's mostly due to lack of standardization, according to Dr. Michota. Hospitals tend to tailor their electronic tools to meet the needs of their specific system of care. As a result, there isn't a standard EHR system that hospitals can buy and implement.

Dr. Michota expressed doubt about the incentives in HITECH for hospitals to get wired. "They say you've got to figure out a way to do it, and if you do it, you might get a few carrots. They haven't made a good business case for hospitals to do this."

Others are more hopeful. Mr. Brown of Inova said that there is the incentive to boost physician recruitment. Many graduating residents won't join a health system or practice that's not wired, he said.

Dr. Michota said he wasn't convinced that being a wired hospital is a major selling point. Some doctors may prefer to work with a wired hospital, and "some physicians who like paper may run away from wired hospital." Yet, he added, being a wired hospital "may be a marker for a well-organized and well-managed system."

To see the list, visit www.hhnmag.com /hhmag_app/gateFold/pages/JULY10.jsp. ■

Program Encourages Palliative Care Techniques in the ICU

BY MARY ELLEN SCHNEIDER

Critical care and palliative care may seem like opposing concepts, but experts in both fields say bringing palliative care techniques into the intensive care unit can decrease costs and improve patient satisfaction.

A new project launched in partnership with the Center to Advance Palliative Care aims to jump-start the integration of palliative care techniques into ICU programs by providing a slew of online tools and resources.

The IPAL-ICU Project (www.capc.org/ipal-icu), which is partially funded by the National Institute on Aging, includes templates, protocols, quality monitoring tools, and a library of journal citations with the latest evidence about palliative care in the ICU. Through the new Web site, people can also learn how to contact ICU programs that have already integrated palliative care.

The first step for anyone considering introducing palliative care into the ICU is to make the case to the multidisciplinary critical care team and to hospital leaders, said Dr. Judith E. Nelson, the project director for the IPAL-ICU Project and a professor of medicine at Mount Sinai School of Medicine in New York City. But it's not a difficult case to make, she said.

"There is absolutely no downside here," Dr. Nelson said. "There is enhanced care and satisfaction for everyone involved, and efficiencies for the institution and the health care system as a whole. It's really a win across the system, and there aren't that many places or strategies in health care that we can say that about."

Research shows that the use of palliative care consultation programs has resulted in cost savings throughout hospitals, including reductions in ICU costs (Arch. Intern. Med. 2008;168:1783-90). Those savings aren't achieved by increasing mortality, Dr. Nelson said. Instead, the better communication fostered by using palliative care strategies results in a reduced use of nonbeneficial ICU treatments and even a decreased length of stay. "It cuts back on delay and improves communication," Dr. Nelson said.

The biggest barrier is convincing people to let go of the old model of sequential care, Dr. Nelson said. In that model, a patient receives aggressive care in the ICU and, when that is exhausted, moves to palliative care in a hospice setting.

There's a fear that the introduction of palliative care early on means that the intensive care will somehow be diminished, she noted. "That's not necessary, and it's not optimal," Dr. Nelson explained. When done right, palliative care should support an aggressive care plan by making sure it is tailored to the patient's needs and desires. Palliative care can also help identify untreated pain and other symptoms.

Over the last decade, palliative care programs in general have spread across the country and increasingly been embraced by physicians. Dr. Nelson said she hopes that palliative care in the ICU setting will have similar success.

The concept of palliative care in the ICU is already catching on, noted Dr. J. Randall Curtis, professor of medicine at the University of Washington and head of the section of pulmonary and critical care medicine at Harborview Medical Center in Seattle. Just a few years ago, many people thought the very idea was crazy, he said—but he doesn't hear that anymore.

"I think people are still struggling with how to do it well, but I think there's a common acceptance that this is an important part of critical care," said Dr. Curtis, who is a member of the IPAL-ICU advisory board.

Still, ICUs can be a difficult place to integrate palliative care, he cautioned.

For starters, critical care units are busy places. Physicians and nurses working there need to balance considerations such as providing supportive palliative care against the need to focus on reducing central line infections and using ventilators appropriately. In addition, palliative care isn't the primary goal in the ICU—so the clinicians there need training on how to provide both types of care.

Another potential pitfall can be a "clash of cultures" between the ICU team and palliative care consultants, Dr. Curtis said. Palliative care specialists need to learn about the culture of the ICU, or they risk coming in with the attitude that the critical care team is being overly aggressive in their approach to some patients. That can happen if they don't understand the outcomes of conditions commonly treated in the ICU.

Palliative and critical care teams need to operate on the same page, agreed Dr. Daniel E. Ray, director of the palliative medicine fellowship program at the Lehigh Valley Health Network in Allentown, Pa., and a member of the advisory board for the IPAL-ICU Project. Otherwise, it opens up the possibility that patients and families could receive conflicting recommendations from providers.

The IPAL-ICU Project resources should go a long way to helping institutions get started on the concept. However, he cautioned that the resources should be customized to the unique culture of each hospital, and that leaders need to work on getting buy-in from everyone on the team to ensure that the templates are actually used. ■

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