



What is Quality?

by Kerrie Burns, RN, DQM

Patients and families know quality care when they experience it. A nurse's response time, a doctor's bedside manner, the hospital's atmosphere—all of these things affect how people feel about the quality of their healthcare.

When hospitals talk about quality, it is generally in reference to very specific clinical data collected and analyzed over a period of time. Quality measurement isn't always easy. Different agencies and groups have different ways of reporting clinical outcomes that can affect the way they rate a hospital on a certain quality measure. Reporting systems can also be cumbersome or costly, making ratings even more difficult to produce.

Quality data show how well an institution achieves desired health outcomes for a particular procedure,

often by tracking how closely clinical staff meet standards of care. High standards of care should reflect the following:

Safe: Avoiding injuries to patients from the care that is intended to help them.



Effective: Providing services based on scientific knowledge and best practice.

Patient-centered: Providing care that is respectful of and responsive to individual patient preferences, needs and values, ensuring those patients' values guide all clinical decisions.

Timely: Reducing waits and sometimes harmful delays for both those who receive and provide care.

Efficient: Avoiding waste, including waste of equipment, supplies, tests, ideas and energy.

Equitable: Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socio-economic status.

Measuring quality data allows us to see where we are providing the best care and helps us identify areas for improvement.

The important thing to remember is that staff at CSH have an important role to play in health care quality improvement. Let's work together to provide the best Quality Care for all our patients and families.



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Look for

LTCH News



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From the desk of the CEO

Despite receiving certificate of need (CON) approval to build our own facility in Pineville, we have already altered our project and submitted a “change of scope” to our original CON. The new CON will include a new inpatient rehabilitation hospital as well as the LTAC hospital. The new project will include an additional 40,000 square feet to house the Carolinas Inpatient Rehabilitation Hospital. The new hospital will relocate 19 beds from the current location on the 6th floor inside Mercy Hospital as well as ten beds from the CIR hospital located on CMC Main’s campus.

The new project will allow us to meet the future needs of our hospital (40 private beds versus the 30 private and 10 semi-private beds we have now) while also focusing on the health care model of the future known as Accountable Care Organizations (ACO). Medicare has piloted new ways to reimburse all providers as a way to encourage collaboration and cost efficiencies. By being on the same campus with an inpatient hospital, inpatient rehabilitation, physician services and others, we will be a significant player in the new ACO model.

We will operate similarly to the way we do presently, in terms of having a purchased service agreement with CMC-Pineville to provide services to our patients, such as radiology (although we will have our own CT scanner), laboratory, pastoral care, security and a host of others. We will continue to be an independent hospital though, just as we are today.

By submitting the “change of scope” CON, we will not begin construction on the new hospital until mid summer of next year. We expect to receive approval for our “change of scope” in late March to late April of 2012. Upon approval we will work with architects and contractors to begin construction and will hopefully be in our new “home” by the summer/fall of 2013. It is an exciting time for Carolinas Specialty Hospital.

Dan

Easing Pain—Palliative Care is Not What You Think

Taken from AARP-June 2011 Issue

Written by Karen Rafinski—a freelance medical and science writer based in Boston.

For Gail Cooney, 59, palliative care means yoga, acupuncture and counseling to help her through aggressive chemotherapy for her ovarian cancer. For 93-year-old Jack Hilder, it means home visits that help him keep living independently in a Chicago suburb despite a stroke that has limited his mobility. Palliative care can help ease the burdens of complex illnesses like cancer, heart disease and diabetes, but confusion and fear keep many from getting this service. Like hospice care, with which it is often confused, palliative care focuses on helping patients with their pain and

symptoms, and offering counseling and other services. But if hospice care is about a good death, palliative care is about making the most of life with a serious illness, whether the disease is terminal or not. “Doctors think that you only call palliative care when your patient is about to die,” says Diane Meier, director of the Center to Advance Palliative Care in New York. “Patients don’t know what it is and don’t demand it. They don’t realize they have a right to care focused on improving function and quality of life.”

Cooney, of West Palm Beach, Fla., recently finished six months of chemotherapy. “I’m still working, and I give a lot of credit for that to a strong palliative care program,” she says.

Palliative care takes a team approach, providing a doctor, nurse, social worker

and chaplain working together to go beyond strictly medical issues to address all of a patient’s needs. That could include managing pain and nausea associated with a disease as well as counseling or help in navigating the health care system. About 58 percent of U.S. hospitals provide palliative care, according to the Center to Advance Palliative Care, a number that has more than doubled since 2000.

Palliative care is a relatively new specialty, but studies already have found it makes a difference. For example, lung cancer patients who received early palliative care, along with standard treatment, on average lived almost three months longer than those who didn’t, according to a 2010 study in the *New England Journal of Medicine*.

(continued on page 5)

Introducing Mary L. Piepenbring, ACSW, LCSW

Mary L. Piepenbring is vice president of The Duke Endowment. She is responsible for Health Care and Evaluation for The Duke Endowment, a Charlotte-based private philanthropic foundation. Ms. Piepenbring is a graduate of The University of South Carolina with a Bachelor of Arts Degree in Psychology and a Master of Social Work degree. She is a 2009 graduate of the Harvard Business School Strategic Perspectives in Nonprofit Management Program.

She has worked in various positions in hospital administration in North Carolina and South Carolina and held the position of vice president in administration for seven

years at the Carolinas HealthCare System in Charlotte, North Carolina prior to joining The Duke Endowment in 2000.

Ms. Piepenbring has professional affiliations with the American College of Healthcare Executives, Grantmakers in Health, and the National Association of Social Workers. She is a Hull Leadership Fellow with the Southeastern Council of Foundations.

Ms. Piepenbring is the 2008 recipient of the Ronald H. Levine Legacy Award for contributions to Public Health in North Carolina and the 2010 North Carolina Hospital Association Meritorious Service Award. She is a member of the North

Carolina Medical Care Commission and a board member of the North Carolina Center for Hospital Quality and Patient Safety, the Carolinas Specialty Hospital, and the South Carolina Office of Rural Health. She serves on the Editorial Board of the North Carolina Medical Journal and participates in a number of community and philanthropic organizations.



Long-Term Care Hospital Improvement Act of 2011

Background:

Long-term care hospitals (LTCH) are required by the Medicare program to have an average length of stay of greater than 25 days. In 2004, and most recently in 2011, the Medicare Payment Advisory Commission recommended that the Centers for Medicare and Medicaid Services (CMS) establish additional patient and facility criteria to better define LTCHs. In 2007, the *Medicare, Medicaid and S-CHIP Extension Act* added some very basic LTCH criteria, and called for more comprehensive criteria recommendations from CMS. To date, CMS has not recommended patient and facility criteria for LTCHs.

American Hospital Association (AHA) View:

Congress should establish patient and facility criteria to distinguish LTCHs from other provider settings. *The Long-Term Care Hospital Improvement Act of 2011*, S. 1486, introduced by Sens. Pat Roberts (R-KS) and Bill Nelson (D-FL), would implement new patient and facility criteria

and alleviate the negative impact of the “25% Rule.” This legislation reflects input from a balanced cross-section of LTCH leaders and other hospital experts. S. 1486 would ensure that the right patients are treated in LTCHs. Below is an overview of the bill.

Patient Criteria. Patient criteria ensure that all potential LTCH patients are screened prior to admission through a standardized process that requires physician sign-off before a patient can advance to the LTCH for physician examination. Under S. 1486, all new patients would be examined by an LTCH physician during the first 24 hours after admission to assess whether LTCH-level care is reasonable and necessary for the patient. Physician attestation that the patient meets the criteria would be required for LTCH care to proceed. LTCH patients would then be examined on a weekly basis by a physician to validate whether the patient’s condition continues to require hospital-level care.

Facility Criteria. Facility criteria would establish common requirements for the programmatic, personnel and clinical

operations of an LTCH. In addition, LTCHs would be required to demonstrate that 70% of patients meet criteria that demonstrate that LTCHs focus on treating medically complex patients and patients requiring extended stays.

LTCH 25% Rule. In the absence of LTCH criteria, CMS instituted the “25% Rule” in 2004 to reduce access to LTCH services. The rule, along with the very short-stay outlier (VSSO) policy and CMS’s planned budget-neutrality adjustment, are blunt payment policies that should be replaced with criteria based on patients’ clinical needs. S. 1486 would replace these policies with patient and facility criteria that clarify the specific and unique role of LTCHs in the continuum of care, ensure LTCHs are treating high medical acuity patients, and bring uniformity to the LTCH field.

The AHA urges Congress to pass the Long-Term Care Hospital Improvement Act of 2011, S. 1486.

Summary taken from the American Hospital Association website at:

www.aha.org

Happy Anniversary CSH Team!



August—October

One Year

Jantzen Cranford

Two Years

Julie Agnew

Derrick Jay

Candice Gibson

Wanda Hudnall

Eric Mares

Candace Vangile

Three Years

Yukishia Austin

David Crowe

Margurite King

Joel Kosches

Gertrude Nelson

Carlos Ramirez

Jennifer Watkins

Rebecca Wernstrom

Four Years

Hajrudin Begic

Halina Brengel

Valerie Washington

Five Years

Dionne McLain-Tindall

Aditi Mehta

Nick Primo

Six Years

Paige Baggett

Delilah Burnett

Elvira Cornelius

Loudell Mobley

Thelma Parr

Leigh-Anne Sessoms

Andrea Webb

Seven Years

Shelia Bost

Thank you for your years of hard work and dedication.

New Employees

August—October

Jorene Bessman

Courtney Denson

Anthony DesRavines

Sarah Gallichant

Dana Huether

Jessica McLain

Kathleen McLeod

Welcome to those of you new to our team!

Flu Shots are Still Available!

by David Bowers, RN, BSN, MBA/MHA

How Flu Spreads:

Person to Person

People with the flu can spread it to others up to about 6 feet away. Most experts think that flu viruses are spread mainly by droplets made when people with the flu cough, sneeze or talk. These droplets can land in the mouths or noses of people who are nearby or possibly be inhaled into the lungs. Less often, a person might also get the flu by touching a surface or object that has flu virus on it and then touching their own mouth or nose.

(To avoid this, people should wash their hands often with soap and water. If soap and water are not available, use an alcohol-based hand rub. Linens, eating utensils, and dishes belonging to those who are sick should not be shared

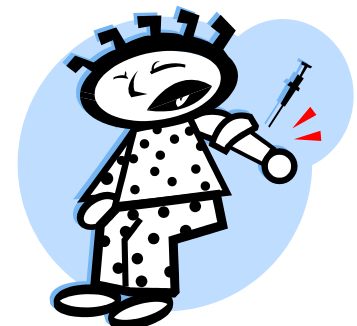
without washing thoroughly first. Eating utensils can be washed either in a dishwasher or by hand with water and soap and do not need to be cleaned separately.)

The Flu Is Contagious

Most healthy adults may be able to infect others beginning 1 day **before** symptoms develop and up to 5 to 7 days **after** becoming sick. Children may pass the virus for longer than 7 days. Symptoms start 1 to 4 days after the virus enters the body. **That means that you may be able to pass on the flu to someone else before you know you are sick, as well as while you are sick.** Some persons can be infected with the flu virus but have no symptoms. During this time, those persons may still spread the virus to others.

The above information was referenced from the CDC website (<http://www.cdc.gov/flu/about/disease/spread.htm>)

Please make sure you get your flu shot from Employee Health. We still have shots available if you need one or reconsider!!!



Happy Birthday to You!

<u>November</u>				<u>December</u>			
David Bowers	11/8	Portia Davidson	11/13	Gerturde Nelson	12/4	Valerie Washington	12/13
Georgette Cameron	11/8	Brian Stroman	11/14	Melissa Tyo	12/4	Elvis Velic	12/14
Shawna Coye	11/8	Noreen Kipp	11/17	Jan Plyler	12/9	Carmita Edison	12/14
Cheryl Hendren	11/9	Rose Faulhaber	11/23	Julius Hobbs	12/9	Georgia Hansen	12/16
Regina Sifford	11/9	Frederick Crosby	11/26	Dana Martin	12/9	Montoya Regan	12/17
Jarisa Neal	11/10	Traci McSwain	11/28	Anne Boatenreiter	12/10	Nine Wilson	12/21
				Ellen Anin	12/10	Pat Adeigbo	12/26
				Crystal Pamilton	12/12	Mimi Wubeshet	12/26
				Jessica Robinson	12/12	Dionne Tindall	12/27
						Sandy Louissaint	12/31



Palliative Care Is Not What You Think (cont'd from page 2)

This may be because people whose pain and symptoms are well managed can tolerate more aggressive or longer treatment, experts say. The patients in the study also experienced less depression and better quality of life.

Other research has shown that palliative care reduces spending on expensive hospital care that doesn't prolong or improve patients' lives. Although Medicare has no specific palliative care benefit, many treatments and medications for palliative care are covered through standard benefits. With private insurance, coverage depends on the company and the policy and what specific services you need.

The barriers

Sometimes doctors and patients confuse palliative care with hospice care, which is for people who no longer need or want to treat their condition but want help managing their pain. Palliative care, on the other hand, is often meant to help people who are still fighting their disease. But some fear palliative care because they think it means giving up. As a result, many patients don't seek this care early in the course of their illness, when it could do the most good.

Also, many patients and doctors have an all-too-human tendency to avoid talking frankly about the seriousness of a diagnosis, which may prevent the subject of palliative care from even being discussed. "A lot of physicians aren't comfortable talking about what we do if the chemo doesn't work," says Andrew Putnam, M.D., director of palliative care at Georgetown Lombardi Comprehensive Cancer Center in Washington. That's a missed opportunity, he says, because palliative care teams are trained to help patients understand all their treatment options as well as the quality-of-life ramifications, so they can make truly informed decisions about what's best for them.

Often patients assume their doctors will take care of their pain and don't realize that in our specialized medical system, the oncologist or the cardiologist has not been well trained in pain and symptom management, Meier says. Nor do specialists have a lot of time to spend on quality-of-life issues. Because they are focused on treating the illness, doctors may not realize how bad a patient's symptoms are or that they are overlooking better options for reducing pain. "The system is broken for the

sickest and most vulnerable patients," Meier says. "The minute you get a serious illness, you get referred to a specialist. The specialist is focused on his or her organ or his or her disease. They're not focused on the whole person."

What you can do

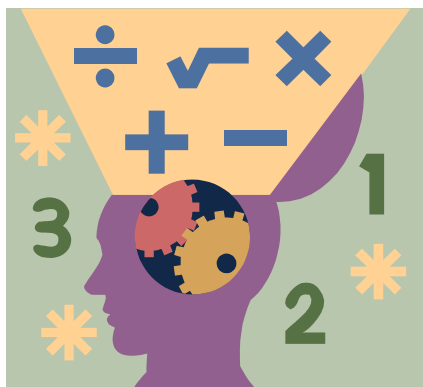
There are steps people can take to ensure they get the best care possible.

First, have a frank discussion with your doctor about your diagnosis, your prognosis and your goals for treatment. Ask for a referral to palliative care. If your doctor doesn't cooperate, ask for a second opinion or consider finding a new doctor, advises Thomas Smith, M.D., a palliative care researcher at Massey Cancer Center of Virginia Commonwealth University and director of the palliative care program there. "It requires gumption on the part of the patient and their family, but it's absolutely necessary for good care of the seriously ill patient," says Smith. "Patients should not be afraid to ask for a palliative care consultation. It doesn't mean they'll die sooner. In fact, they might live better and longer."

Delirium and Cognitive Impairment of the Hospitalized Patient

Every day, 30,000 to 40,000 ICU patients in the United States are suffering from acute brain dysfunction called delirium. This problem is getting larger every year due to the aging of our population. Traditionally, this is called “ICU psychosis” and professionals have not thought it to be clinically significant. Using clinical tools designed and validated at Vanderbilt University, the ICU cognitive impairment study group has now shown that delirium is associated with a tripling of the risk of death within six months of ICU.

Even considering other factors such as age, severity of illness, duration of coma, and the use of psychoactive medications, every day spent in delirium by ICU patients was associated with a 10% higher risk of death and worse long-term cognitive function among survivors. Thousands of ICUs around the world are now implementing routine monitoring for delirium based on this work, which has been translated into eight languages, and national guidelines have embraced delirium monitoring for the first time. Ongoing clinical trials are now exploring the safest and most effective ways to prevent and treat ICU delirium in hopes that such treatments will not only reduce delirium but also the high morbidity and mortality associated with it.



According to the National Research Council, “for many people in good physical condition who succumb to an acute illness, cognitive decline is the main threat to their ability to recover and enjoy their favorite activities and for those whose physical activities are already limited, cognitive decline is a major additional threat to quality of life”.

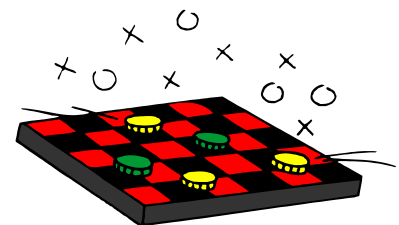
We know that acute lung injury (ALI) and acute respiratory distress syndrome (ARDS) patients are at great risk for multiple organ dysfunction syndrome (MODS), and that the brain is one of the most frequent organs involved in this process. Furthermore, both the lay public and health care professionals are becoming increasingly concerned not only with survival, but also with the quality of patients’ lives, which is determined in large measure by their neurophysical outcomes. At 6 months following ALI/ARDS, the proportion of patients complaining of psychiatric, cognitive and neurologic symptoms were 57%, 32% and 44% respectively. In our own studies and those of others recently, it has been determined that up to 80% of patients experience acute delirium in the ICU during their bout of ALI/ARDS.

We have shown that delirium in the ICU is associated with a nine times higher likelihood of cognitive impairment at the time of hospital discharge. Lastly, 33% to 80% of survivors of ALI/ARDS have long-term cognitive impairments when studied with comprehensive tests. This sort of ongoing brain dysfunction can be akin to an acquired dementia of sorts. As the medical community strives to improve the outcomes of patients with ALI/ARDS, it is imperative that we begin to focus on the brain as an important organ that suffers great risk during the ICU stay and beyond.



What can be done about delirium and cognitive impairment now?

1. Staff and family should monitor for signs of delirium and notify appropriate personnel in an attempt to deter delirium from getting worse. Decreased consciousness and lethargy may be the first sign of delirium.
2. Avoid sedating medications unless necessary. If a patient's pain can be managed by Tylenol or another non-sedating medication, try that first before moving onto something more potent.
3. Help patients maintain an appropriate sleep-wake cycle. Keep it quiet and dark in the room at night. Have lights on and complete most tasks and activities during the day.
4. Play games that challenge the mind if the patient is able to participate such as solitaire, connect four, Sudoku puzzles, crosswords and word jumbles.



Referenced from www.ardsusa.org.
Written by Dr. Wes Ely and team from Vanderbilt University. Submitted by Janet Combs.

Understanding Your Health Information Manager

Submitted by Andrea Webb, HIM

An accounting of every action during a consumer's healthcare encounter, including the diagnosis and treatment of a condition, is documented within a health record. From the nurse's assessment to the procedure performed to a prescription written by a physician, this data is collected to enable the best quality of care given, fulfill legal requirements and serve evidentiary purposes. While it serves as part of the legal record of business as defined by a healthcare organization, the health record is also the staple that helps guide the continuity of a consumer's care.

In the United States alone, there are an estimated 1.2 billion ambulatory care visits (physician offices, hospital outpatient and emergency departments) per year. The estimate does not include hospital, long-term care, hospice, or other types of healthcare visits. The amount of documentation as a result of the numerous healthcare encounters adds up to a lot of data and information that is the lifeline of health information management (HIM).

AHIMA's Pocket Glossary of Health Information Management and Technology defines the practice of HIM as "an allied health profession that is responsible for ensuring the availability, accuracy and protection of the clinical information that is needed to deliver healthcare services and to make appropriate healthcare-related decisions."



Some of the core principles of HIM can further be defined as:

- **Availability**—HIM professionals ensure consumer health information is readily available only to those who need it, when they need it. They ensure the appropriate and rightful access to health information only by those legally authorized to have it.
- **Accuracy**—HIM professionals manage all information collected about an individual's health to ensure it is correct and ensure timeliness, authenticity and precision to meet all state and federal regulations and optimal continuity of care outcomes.
- **Protection**—HIM professionals pledge to keep personal health information confidential from anyone except those who have a legal right to see or review it. They employ privacy and security measures to optimally safeguard health information in all forms—paper, electronic, in transit and at rest.

This is a time of continuous change for the healthcare industry and the way HIM professionals practice. New [state and federal] regulations and requirements arise as old ones change or become obsolete. Health information is quickly evolving from paper to various types of electronic media, placing electronic media center stage. For example, the electronic health record (EHR) is more prevalent in health organizations nationwide and gains in importance as the federal government promote and support health information technology (HIT).

HIM professionals are faced with new challenges of managing electronic health information as well as maintaining the old requirements for a sound and legally compliant health record. The three HIM principles mentioned above are a promise HIM professionals everywhere strive to keep every day. Those principles can only be achieved through the many tasks such as releasing health information to others, exercising documentation best practices, and the proper coding and billing of care rendered, all of which need to be properly managed and maintained by the expertise of an HIM professional.

Do you know your health information manager?

by Angela K. Dinh, MHA, RHIA, CHPS

AHIMA. Pocket Glossary of Health Information Management and Technology, Chicago, IL: AHIMA, 2010, 130.

Quiz (answers on back page)

1. Accuracy of information is an HIM principle that ensures correct and timely data to meet state and federal regulations.
a. True b. False
2. There are an estimated 1.2 billion hospital visits each year.
a. True b. False
2. Which is not one of the HIM principles?
a. Protection
b. Availability
c. Accuracy
d. All of the above are principles.
4. Which statement is true?
a. HIM professionals employ privacy and security measures to protect all types of consumer health information.
b. HIM professionals manage electronic health information only.
c. HIM professionals manage paper health records and IT manages the electronic health record.
d. HIM professionals provide access to health information to everyone who wants it.
5. Which statement is NOT true?
a. Availability of health information is the appropriate and rightful access to health information only to those legally authorized to have it.
b. Protection is the practice of ensuring paper health information is safeguarded.
c. Accuracy in health information means it is correct, timely and appropriately authenticated.
d. Protection is the practice of ensuring the confidentiality of health information.



What is an LTAC?

An LTAC is a Long Term Acute Care Hospital for patients that continue to be acutely ill and require a physician's care each day, just as in a "traditional" hospital. The patients are medically complex and are not going to be ready for discharge in a short period of time.

Carolinus Specialty Hospital has been providing Long Term Acute Care services to the Charlotte region for over six years. Our dedicated team of professional healthcare providers are exceptionally qualified to meet the needs of the LTAC patient.

Each patient at Carolinus Specialty Hospital receives a customized plan of care to meet their specific needs. Each patient's treatment plan is updated weekly by a multidisciplinary team, including the patient and their family. The goal for each of our patients is to return to their highest level of wellness.

Visit us on the web at www.cshnc.com

Hospital Uniforms Harbor Harmful Bacteria, Study Says

Sep 03, 2011

Researchers found that exactly half of all the cultures taken, representing 65 percent of RN uniforms and 60 percent of MD uniforms, harbored pathogens.

More than 60 percent of uniforms worn by hospital doctors and nurses tested positive for potentially dangerous bacteria, according to a study published in the September issue of the *American Journal of Infection Control*, the official publication of APIC—the Association for Professionals in Infection Control and Epidemiology.

A team of researchers led by Yonit Wiener-Well, M.D., from the Shaare Zedek Medical Center in Jerusalem, collected swab samples from three parts of the uniforms of 75 registered nurses and 60 medical doctors by pressing standard blood agar plates at the abdominal zone, sleeve ends, and pockets.

The researchers at this 550-bed, university-affiliated hospital found that exactly half of all the cultures taken, representing 65

percent of the RN uniforms and 60 percent of the MD uniforms, harbored pathogens. Of those, 21 cultures from RN uniforms and six cultures from MD uniforms contained many drug-resistant pathogens, including eight cultures that grew methicillin-resistant *Staphylococcus aureus* (MRSA). Although the uniforms themselves may not pose a direct risk of disease transmission, these results indicate a prevalence of antibiotic-resistant strains in close proximity to hospitalized patients.

"It is important to put these study results into perspective," said APIC 2011 President Russell Olmsted, MPH, CIC. "Any clothing that is worn by humans will become contaminated with microorganisms. The cornerstone of infection prevention remains the use of hand hygiene to prevent the movement of microbes from these surfaces to patients."

"New evidence such as this study by Dr. Wiener-Well is

helpful to improve the understanding of potential sources of contamination but, as is true for many studies, it raises additional questions that need to be investigated," added Olmsted.

According to the World Health Organization, the risk of health care-associated infection (HAI) in some developing countries is as much as 20 times higher than in developed countries. Even in hospitals in developed countries like Israel, the site of this investigation, and the U.S., HAIs occur too often, can be deadly, and are expensive to treat. HAI prevention is therefore the best approach for patient safety. Infection preventionists, in collaboration with direct care providers, can prevent more than half of HAIs by applying proven prevention practices as part of a comprehensive infection prevention and control program.

Occupational Health & Safety, 2010, 1105 Media, Inc.