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Spring 2009

CATHOLIC HEALTH EAST

# HORIZONS

## Improving Care with Patient Simulators

**O**ne of CHE's key strategies for improving quality system-wide by the year 2017 is to "... implement recognized, disciplined, evidence-based processes and techniques to improve continually in areas of quality and safety."

A new program introduced last year by CHE's claims services and clinical loss prevention department is focused on helping to improve quality and outcomes in one specific area: childbirth. "We evaluated risk reduction strategies with the goal of preventing adverse outcomes during the labor and delivery period and to improve patient care of the mother and child when complications do arise," said Bridget M. Bailey, B.S.N., J.D., risk manager, CHE's claims services and clinical loss prevention department.

Although the occurrence of adverse outcomes is low in obstetrics, it can be costly with high litigation costs and devastating to those affected. Simulation training in an OB environment was identified as an innovative approach to improving maternal-child care, and thus the clinical education initiative for OB providers on NOELLE™ and her baby HAL®, were born.

Gaumard® based in Miami, Fla., providing "simulators for health care education" introduced NOELLE, as part of a 'safe motherhood' initiative. Now she and her baby HAL are helping to



Walter Jarrett, M.D., and St. Mary's Family Birth Center nurses Tabby Bonner, R.N.C., and Hope DeLaille Collier, R.N., participate in a recent emergency training session using robot simulator NOELLE, while Family Birth Center Director Kem Mixon, R.N., looks on.

educate clinical staff throughout CHE. The wireless mannequins help train providers in labor and delivery settings. By doing so, the staff learns to work as a team and reduce medical errors without risk to patients.

These life like birthing robots simulate actual fetal deliveries. Carefully scripted drills are conducted to demonstrate different scenarios including head first,

breech and cesarean section deliveries. The life like dolls can speak and send electrical signals to simulate life-threatening conditions. For example, baby HAL's cheeks glow blue if he doesn't get enough oxygen.

This new teaching tool is designed to provide a complete birthing experience

*continued on pages 8 & 9*

# Bar Code Technology Helps Reduce

*One technological solution to help prevent medication errors in hospitals is known as bar code medication administration (BCMA). BCMA technology involves placing an identifying bar code on each medication, which is machine-readable by an optical scanner. Before medications are administered, BCMA matches the right medication to the right patient at the right time.*

Upon hospital admission, a bar code is issued to each patient, identifying that particular individual when it is scanned. When it is time for a patient to receive his/her medications, the nurse scans the bar code on the patient's ID bracelet, and then scans the bar code on the medication. The BCMA application makes sure that the right dosage of the right medication is given to the right individual at the right time. If there is a discrepancy with any one of these—wrong medication, wrong dosage, wrong patient or wrong time—the computer will alert the nurse, who can then take appropriate action.

"Bar code technology has given the nurses another layer of checking at the bedside," said Anna Alderuccio, R.N., M.S.N., director of clinical informatics, St. Mary Medical Center, Langhorne, Pa. "We've also gotten very positive feedback from our patients. They feel more confident in our hospital because we have taken these steps to ensure their safety."

St. Mary Medical Center is just one of the RHCs within Catholic Health East using Meditech's BMV (Barcode Medication Verification) application software. Mercy Philadelphia Hospital and Mercy Fitzgerald Hospital, both members of Mercy Health System of Southeastern Pennsylvania, use Siemens' MAK (Medication Administration Check) application software. Each facility also chose the type of equipment they wanted to use with the application. St. Mary Medical Center, for example, purchased wireless Rio™ carts from Omnicell with tethered scanners for most inpatient areas. One 15-bed unit is piloting



*Close up of the handheld scanner used to scan the patient's ID bracelet and medication. The bar code on the patient's ID bracelet is linked to her clinical information, including what medications the physician has prescribed for her during her stay.*

*"We've also gotten very positive feedback from our patients. They feel more confident in our hospital because we have taken these steps to ensure their safety."*

**Anna Alderuccio, R.N., M.S.N.,  
director of clinical informatics, St. Mary Medical Center**

the use of bedside computers with wireless scanners. Mercy Philadelphia and Mercy Fitzgerald purchased battery-operated Levitator™ computer carts from Stinger and handheld scanners with wireless access. They purchased one computer per nurse—including per diem and agency staff. Different manufacturers aside, the technology is the same.

"When the patient's bar code is scanned, the application opens a screen with that patient's information," said Cara McDevitt, R.N., nursing informatics coordinator, Mercy Philadelphia Hospital. "The nurse can see all the medications that are prescribed for that patient. The nurse can also enter clinical data such as heart rate and blood pressure, which will be transferred to their chart."

Before they went live, the project leads at each facility, along with Siemens and Meditech specialists from CHE, painstakingly prepared the application—how it would look on the screen and how nurses would access the software. Once the application was built, a core team was trained and then conducted extensive

testing of the equipment. These same individuals then assisted in training the remaining clinical staff.

"Having the front line nursing staff involved in testing and training was instrumental to the success of the project," said CathyLynne Burns, R.N., M.S., nursing informatics, Mercy Fitzgerald Hospital. "Listening to their suggestions and making adjustments accordingly fostered an extremely important buy-in from the nurses. Many volunteered to take an active part in training and willingly took ownership of supporting the successful go-lives on every floor. They continue to be proactive in refining processes, workflow, application and hardware issues."

The implementation of bar code technology has affected more than just the nursing staff. Before the medication even gets to the floor, the hospital pharmacy is receiving and entering the prescription orders from physicians.

"While the nurses are using this

# Medication Errors Throughout CHE



A nurse at St. Mary Medical Center uses the hand-held optical scanner to scan the patient's ID bracelet before scanning the bar code on the medication.

*“Having the front line nursing staff involved in testing and training was instrumental to the success of the project ... Many volunteered to take an active part in training and willingly took ownership of supporting the successful go-lives on every floor.”*

**Cathyllynne Burns, R.N., M.S.,  
nursing informatics, Mercy Fitzgerald Hospital**

application daily at the bedside, the pharmacists are building and maintaining the system in the background. We need to validate the bar codes every single day,” said Suzette Cunicelli, R.Ph., pharmacy operations manager, St. Mary Medical Center. “Implementing this technology has actually brought the pharmacy and nursing staffs together. We now have a better understanding of what the nurses need on the floor and how they work.”

Cunicelli also said the new technology allows the pharmacists to have access to additional information during the order entry process.

“Having clinical information in real-time, such as time of last dose, is important for the pharmacist if there is a need to update a medication order,” said Cunicelli. “Previously, we’d have to call

the floor and find the nurse. Now we can look it up and enter the appropriate time for the next dosage.”

If they could change anything about the implementation process, both McDevitt and Burns agree that having the hardware and equipment earlier would have allowed them more time to test both the application and wireless access before introducing it to the staff.

“Issues with equipment caused some added stress, especially to those with less computer experience,” said Burns. “The nursing staff had to learn a new program, adjust to a new workflow and troubleshoot new equipment all at the same time.”

Overall, the implementation of BCMA has improved communication between the hospital pharmacy and nursing staff, allows more efficiency during prescription

## The Prevalence of Medication Errors

- It is estimated that between 380,000 and 450,000 preventable medication errors occur in U.S. hospitals each year, resulting in \$3.5 billion in additional costs.
- The error rate in administering medication in U.S. hospitals averages one patient per day per hospital.
- 7,000 deaths occur each year that are directly attributable to medication errors.
- Medication error is the eighth leading cause of death in the U.S.

Sources: The Joint Commission and the Institute of Medicine

order entry and also helps the hospitals comply with standards and patient safety goals as set forth by The Joint Commission and CMS (Centers for Medicare & Medicaid Services).

As of now, the following acute care hospitals within CHE have already implemented BCMA technology: Our Lady of Lourdes Medical Center, Camden, N.J.; Lourdes Medical Center of Burlington County, Willingboro, N.J.; St. Mary Medical Center, Langhorne, Pa.; Holy Cross Hospital, Ft. Lauderdale, Fla.; St. Francis Medical Center, Trenton, N.J.; Mercy Philadelphia Hospital, Philadelphia, Pa.; St. Mary's Health Care System, Athens, Ga.; Mercy Health System of Maine, Portland, Maine; Mercy Fitzgerald Hospital, Darby, Pa.; Mercy Suburban Hospital, East Norriton, Pa.; Mercy Medical Center, Springfield, Mass.; Mercy Hospital, Miami, Fla.; and St. James Mercy Health System, Hornell, N.Y. The remaining facilities are scheduled to go live by the end of 2009.

**For more information on BCMA technology, please contact Kathleen Meredith, CHE vice president, clinical transformation, at [kmeredith@che.org](mailto:kmeredith@che.org) or 610.355.2158.**



# CHE Vision Includes Focus on Continuing Care and Senior Services

*Continuing Care Management Services Network (CCMSN) and Catholic Health East Senior Services Management (CHESSM) created to meet the growing needs of the aging population.*

*Sweeping changes are impacting the delivery of long-term care services throughout the nation, and within Catholic Health East. In 2010, there will be an estimated 40.2 million people age 65 and over in the U.S. That's the highest number of 65+ residents in our country's history. By 2020, this population is projected to swell to 54.8 million. That's a 36% increase. As a result of the aging population, meeting the housing and health care needs of this rapidly growing segment of the population has become a major challenge for public policy, sponsors and operators of facilities for the aging. Moreover, consumer preference is in favor of more community and home-based services.*

In 2004, CHE's Sponsors, concerned about the growing need for continuing care services and cognizant of the operational challenges facing our facilities, challenged CHE to recommit to the long-term care ministry. Together with the explosive growth of "alternative" community and home-based services, these issues led to the development of a new vision for continuing care. This new vision called for commitment to continuing care services by all within CHE and the incorporation of continuing care strategies as part of each RHC's strategic plan, to ensure that continuing care services are positioned as a core ministry of CHE and integrated into the "mainstream."

Continuing care services and revenues throughout CHE have grown significantly in the past few years. Our ministry now includes 36 freestanding and hospital-based long-term care facilities, 12 assisted living facilities, five continuing care retirement communities, and 25 home health/hospice agencies. Last year, CHE provided over \$500 million in services for

seniors outside of the hospital/acute care realm.

In 2007, CHE decided to harness the continuing care expertise that already existed within our health system and make it available to other RHCs/JOAs. John Capasso, who came to the CHE System Office by way of St. Joseph of the Pines, became the president and chief executive officer of a new CHE division: Continuing Care Management Services Network (CCMSN). CHE's three continuing care RHCs—St. Joseph of the Pines, Southern Pines, N.C.; Mercy Community Health, West Hartford, Conn.; and Mercy Medical, Daphne, Ala.—have direct reporting relationships to Capasso. Capasso and his team also work collaboratively with continuing care leaders at other RHCs. By using CHE's collective resources, the goal of CCMSN is to enhance the growth and long-term success of continuing care ministries throughout CHE.

"Working together, we have real opportunities to impact the lives of seniors



John Capasso, president and CEO, CCMSN

*"By using CHE's collective resources, the goal of CCMSN is to enhance the growth and long-term success of continuing care ministries throughout CHE."*

John Capasso, president and CEO, CCMSN

in America. These services are important to the community, and we're organized in a way that will enhance the delivery of service and achieve our strategic goals," said Capasso. "We are blessed to have the expertise across the System, and we can build further alliances to maximize our collective value to our patients, communities and each other."

CCMSN consists of a core staff that has continuing care expertise in finance, quality, information management and operations. CCMSN focuses on operational excellence and strategic execution to optimize how continuing care services are managed and operated. Services provided include:

- Onsite management and consulting services;
- A wide range of financial services and support, including performance analysis, budgeting, forecasting and third party billing services;

*continued on page 6*



# Retaining New Nurses

## Nurse Residency Program Debuts at Holy Cross Hospital

*The U.S. is in the midst of a nursing shortage that experts agree will only get worse in coming years. A recent study projected that the nationwide shortage of registered nurses could reach 500,000 by the year 2025. These statistics are rightfully concerning to human resources and nursing departments in hospitals throughout the nation, who face a double-edged challenge: how to first recruit qualified nurses ... and then ... how to retain them.*

Retention poses its own unique challenges. A September 2007 study published in the *American Journal of Nursing* found that 13 percent of newly-licensed RNs had changed principal jobs after one year, and 37 percent reported that they felt ready to change jobs. Even more concerning was a July 2007 PricewaterhouseCoopers' Health Research Institute study that estimated average nurse turnover rate in hospitals at 8.4 percent, but found the average voluntary turnover for first-year nurses was a whopping 27.1 percent. That represents more than one in four first-year nurses!

Holy Cross Hospital decided that it had to do something to improve retention of its first-year nurses. The turnover rate for RNs at Holy Cross for the period January-April 2008, was about 16 percent. Of those RNs who left Holy Cross during that time period, 87 percent had less than two years of service. And turnover is costly: the cost of replacing one nurse is estimated at \$30,000.

After a great deal of analysis and planning, they came up with a solution. Holy Cross Hospital proudly announced the implementation of its Nurse Residency Program, a one year program designed to ease the transition to practice for new graduate nurses in their first professional role. The program was developed by the University HealthSystem Consortium, in



*Below: Darlene Titus, R.N., B.S.N., nurse residency program coordinator, (standing left) with facilitator Jennifer Shapiro, R.N., B.S.N., and residents Heather Sanzari, R.N., and Hema Chanardip, R.N., during a small group discussion.*

collaboration with the American Association of Colleges of Nursing, and is currently being used in 51 sites throughout 27 states. Holy Cross is the first hospital in Florida and the first in Catholic Health East to use this program.

The Nurse Residency Program promises to be a successful recruiting and retention tool for newly graduated nurses. "The program is really good for brand new nurses to share their thoughts and trials and tribulations. Your first year can be overwhelming," said first-year nurse Heather Sanzari, R.N. According to Sanzari, the program is good for morale and she truly appreciates the seminars and small group discussions, where new nurses get hands-on clinical practice and answers to difficult questions. "You don't really learn how to be a nurse until you actually do it a few times. You know the theory. The practical skills you don't learn until you get the hands-on experience."

Other first-year nurses agree. "This gives you a lot of experience you don't get during clinical rotations," said Hema Chanardip, R.N. "Personally, I learn by doing."

The goals of the program are to assist graduate nurses with their transition into the practice environment, develop comfort in the RN role, apply theoretical concepts at the bedside and improve critical thinking abilities. The Nurse Residency Program layers on top of hospital and nursing orientation to provide a structured one year program. The program consists of monthly four-hour seminars which contain educational content, along with small group discussions of professional experiences and case studies. Residents remain in the same small group for the entire year to promote the development of trust and support.

"The Nurse Residency Program is proving to be an invaluable resource for new nurses making the successful transition from the classroom and clinical rotations to the nursing profession," said Nora Triola, Holy Cross Hospital's chief nursing officer. "An excellent recruitment tool, the program also provides the needed support to build new nurses' confidence level and reduces the attrition often seen during the first year of practice."

*continued on page 6*



# CHE Continuing Care and Senior Services

...continued from page 5

- Strategic planning and marketing analysis;
- Quality management and clinical improvement services; and
- Assessing and supporting information technology needs.

In addition to working with these RHCs and supporting the continuing care efforts and needs of others throughout the health system, a for-profit subsidiary corporation, Catholic Health East Senior Services Management (CHESSM) was created. CHESSM (pronounced 'Chessum') was formed to provide consultative and management services to organizations and facilities not affiliated with CHE.

CHESSM assists continuing care programs and services to improve quality, facilitate clinical initiatives, promote innovation and identify and develop model practices for core management

*"CHESSM's goal is to optimize the way in which continuing care services are managed and operated."*

and delivery, clinical outcomes, and medical error and risk reduction. CHESSM's goal is to optimize the way in which continuing care services are managed and operated.

The experts at CHESSM provide help to other organizations in a variety of ways. CHESSM can ...

*... conduct an operational review of an organization or specific components of an organization.* Such a review would identify opportunities for improvement and work plans to improve operations.


*... create a strategic plan.* This service identifies demographic trends and

develops a comprehensive SWOT analysis, leading to the development of short- and long-term goals, strategies and tactics.

*... assist with facility management.*

This service typically involves significant on-site presence, in which the CHESSM staff works collaboratively with an organization's leaders to develop and implement action plans and assist in achieving desired results.

"CHESSM exists to best position continuing care ministries to succeed in the future," said Capasso. "Our experience and expertise in managing and consulting with facilities across continuing care can provide organizations with the support they need to thrive in this competitive and complex industry."

For more information about CCMSN or CHESSM, please contact John Capasso, president and chief executive officer, at [jcapasso@che.org](mailto:jcapasso@che.org) or 610.355.2173. 

## Retaining New Nurses Nurse Residency Program Debuts at Holy Cross Hospital

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In order to maximize the orientation process within the nursing unit, Holy Cross modified the preceptor model, reducing the preceptor's patient load for the first six weeks to allow additional time for him/her to work more closely with the nurse resident. They also extended the length of the orientation for critical care and step-down residents.

The first group of nurse residents met in October 2008 and the result was a resounding success! The second group started in January 2009. Again, the enthusiasm in the room was almost palpable. In order to coordinate with the universities' graduation dates, Holy Cross will be hiring new graduates to start in March and August of each year.

To learn more about the Nurse Residency Program, contact Chrissy Marrero, director of associate training and development, Holy Cross Hospital, at [Chrissy.Marrero@Holy-cross.com](mailto:Chrissy.Marrero@Holy-cross.com) 



Participants in Holy Cross Hospital's first nurse residency program, which started in October 2008, pose for a group shot with the program coordinator and facilitators.



# St. Peter's Announces Affiliation Talks with Other Local Providers

*St. Peter's Health Care Services and two other health care providers in the Albany, N.Y., area are formally discussing an affiliation.*

St. Peter's, Northeast Health and Seton Health announced they have entered formal negotiations intended to lead to an affiliation of the three organizations. During the next 12 months, the organizations will determine their compatibility and how such an affiliation could best serve the community. No operational changes are anticipated during this time.

"The intention of entering these negotiations is to see if there are collaborative ways to improve quality, cost-effectiveness and accessibility of health care in the Capital region and beyond," said St. Peter's CEO/President Steven P. Boyle at a February 25th news conference announcing the memorandum of understanding.

"St. Peter's has a mission to be a transforming, healing presence within the communities we serve. Most important for St. Peter's is that Northeast Health and Seton share a strong, values-based dedication to address today's challenges and improve the health status of our communities."

Northeast, St. Peter's and Seton, who combined have nearly 12,000 employees in more than 125 locations, provide a wide array of services to thousands of residents in the Albany region. These services include: St. Peter's Hospital's state-of-the-art tertiary care services, its community hospice, and two skilled nursing facilities; Northeast's Albany Memorial and Samaritan hospitals, Sunnyview Rehabilitation Hospital and The Eddy's renowned eldercare services including skilled nursing, Alzheimer's, adult day services, home care and community services, and retirement and assisted living; and Seton adds St. Mary's Hospital, a skilled nursing facility, certified home care

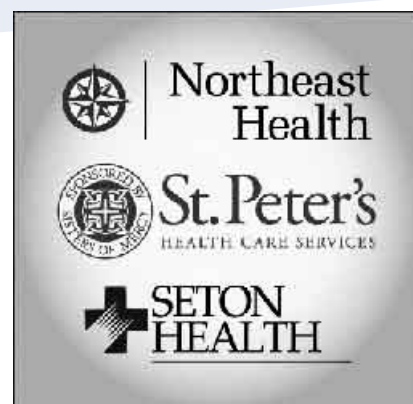


Appearing at a news conference to announce a possible affiliation between their health systems, from left: Gino Pazzagli, president and CEO, Seton Health; Steven Boyle, president and CEO, St. Peter's Health Care Services; and James Reed, M.D., president and CEO, Northeast Health.

agency, 14 physician office locations and an array of specialty services.

Under the anticipated governance model, a new parent corporation would be created that will be secular. This parent corporation would join Catholic Health East as a member, while St. Peter's and Seton would retain their Catholic identities and Northeast would remain secular.

The three health systems have publicly placed quality of care at the top of their list of priorities. The systems intend to use the affiliation to build upon the commitment to quality by sharing best practices, developing common policies, investing in the latest technologies, and drawing from the quality achievements of each institution.



"This is a great opportunity at an appropriate point in our history to preserve and share our heritage of Catholic health care ministry," said Boyle. "This is especially true as we seek ways to improve access to care, particularly for poor and underserved people."



# Improving Care with Patient Simulators

...continued from page 1

before, during and after delivery. NOELLE can tell you what she is feeling, emits pulse rates, breathes and performs other real-life body functions. The life-size, computerized training model “speaks,” her chest rises and falls as she “breathes,” and her lower body is designed to simulate all types of births, including emergencies.

*“The biggest benefit of NOELLE is she allows us to work together under stress and build trust ... the scenarios are as realistic as they can be without using a real patient.”*

**Kem Mixon, R.N., director of St. Mary’s Family Birth Center**

National health care organizations have found that effective teamwork among caregivers can save lives, particularly in the delivery of newborns. In its report “Preventing Infant Death and Injury During Delivery,” the Joint Commission analyzed the cases of perinatal death or major neonatal injury reported in the last eight years. Ineffective communication was identified as the root cause of death in 72 percent of the cases. “Organizational culture,” poor teamwork and chain-of-command issues were also cited when problems occurred. The Joint Commission recommended that organizations undergo specialized team training in perinatal areas.

“By using NOELLE, providers can work together to enhance their communication, teamwork and clinical skills without risk to the patient. This helps our ultimate goal of providing excellent care in crisis events and, in every day care,” said Bailey.

The Family Birth Center at St. Mary’s Health Care System in Athens, Ga., is one of several CHE hospitals currently using the NOELLE robotic birthing simulator to help prepare nurses and physicians for rare but life-threatening birthing emergencies.

“The vast majority of births are safe and uncomplicated,” said Kem Mixon, R.N., director of St. Mary’s Family Birth Center. “But every now and then complications arise that threaten the life or health of the mother and baby. We are committed to being ready to do everything possible to help them.”

Equipped with everything from detectable pulse to bodily fluids to the ability to tell health care workers about history or pain, NOELLE helps staff and physicians learn how best to respond when a real mother and baby have trouble during delivery. Simulations happen in real time under the direction of a training leader who uses a wireless touchpad computer system to guide each exercise. The system features dozens of options the leader can use to create new, unexpected complications and respond appropriately to the actions of the team. In one scenario, the robot may begin hemorrhaging; in another, mother or baby may go into respiratory distress; in another, the baby may present in a breech position. Dozens of scenarios and combinations of crises allow caregivers to hone their skills in unpredictable situations that help prepare them for real-world emergencies.

St. Mary’s Women’s Services Manager Anita Razor, R.N., likens it to the training pilots receive before taking the controls of an aircraft. “If you’re on an airliner and an engine fails, who do you want at the controls, the pilot who has only read about this kind of situation in a book, or the pilot who has actually practiced it in the simulator?” Razor asked.

Added Kenneth Chen, D.O., an obstetrician at Lourdes Medical Center of



*St. Mary’s respiratory therapist Michelle Johnson, R.T., and neonatal intensive care nurse Donna Dorcus, R.N.C., practice an emergency intubation on robotic Baby HAL. As part of the NOELLE birth simulation system at St. Mary’s, Baby HAL uses sophisticated robotics and wireless computer communications to simulate emergency situations, such as a newborn who has stopped breathing.*

Burlington County: “By offering ongoing training in a safe, controlled environment, our perinatal teams can practice handling emergencies and improve their skills in a safe environment without endangering patients.”

Patricia Eaton, R.N.C., a post-partum unit nurse at St. Peter’s Health Care Services in Albany, N.Y., found that the answers she receives during the simulation drills make a difference in how she is able to deliver care in real-life situations.

“We have used the skills we’ve practiced in incidents on the floor,” said Eaton. “It’s a great learning experience.” As a direct result of simulation training, the

effectiveness in high-risk patient situations. “NICU nurses are getting a different perspective. I’m much more in tune to the issues that are going on with the mom that are going to affect the baby.” Riley said. “There is more collaboration between everyone involved in the situation.”

At St. Mary Medical Center, Langhorne, Pa., nurse educator Nellie Renn, R.N.C.-OB, M.S.N., said, “This is a great asset to our staff’s learning and review experience. In a safe learning environment, they can gain familiarity of those rare and potential risky situations that they may never have experienced before.” Her colleague Marie Schickler, R.N.C., M.B.A., director of obstetric services agreed, “We are very excited about this novel approach to help staff become proficient with all scenarios of delivery.”

*“In a safe learning environment, they (the staff) can gain familiarity of those rare and potential risky situations that they may never have experienced before.”*

**Nellie Renn, R.N.C.-OB, M.S.N., nurse educator at St. Mary Medical Center**

Most importantly, Mixon said, the exercises help physicians and nurses bond as a team. “The biggest benefit of NOELLE is she allows us to work together under stress and build trust,” Mixon said. “She’s a great team-builder, and the scenarios are as realistic as they can be without using a real patient.”



*St. Peter’s maternity nurses—from left: Nancy Chevalier, R.N.; Sandra Smith, R.N.; Brenda Bugbee, R.N.; Maureen Cavanagh, M.S., R.N.C.; and Janice Miller, R.N.C.-E.F.M.—are some of the nurses and other health professionals who have participated in simulated emergency training at St. Peter’s. Using robot “mother” NOELLE and her “baby,” HAL, emergency drills helped nurses, doctors and others sharpen their teamwork and other skills during emergencies. Miller, Cavanagh and Patricia Newell-Helfant, C.N.S., were responsible for developing procedures and curriculum for these drills.*

affect that teamwork has on care has become a greater reality for many nurses.

“The training broadens our perspective. You get to learn who all the players are in the units and their roles,” she said. On a personal note, the drills have improved her confidence in working with her colleagues. “I’m able to make suggestions and ask questions without feeling as intimidated,” added Eaton.

Since 1986, Anne Riley, B.S.N., R.N.C., has worked in St. Peter’s neonatal intensive care unit (NICU). While Riley’s job requires her to be prepared for emergency situations related to newborns, the training has improved her

# MIDAS+ Provides a Single Platform for Standardizing Data Collection

*In 2007, a proposal was submitted recommending that Catholic Health East implement the MIDAS+™ software solution, which would provide a single platform for meeting CMS (Centers for Medicare & Medicaid Services) core measure requirements.*

“CHE and its acute care hospitals must be equipped with effective tools to individually and collectively improve the quality, efficiency and value of health care,” said Tom Garthwaite, M.D., executive vice president and chief medical officer, CHE. “Automation and standardization will support enhanced practice in the areas of quality/safety management and reporting, risk management, case management and infection control system-wide.”

The goal of MIDAS+ is to significantly minimize manual data collection, abstraction and reporting. Also, it will streamline and standardize data collection and reporting across CHE, as well as provide real-time information in order to allow for better and timelier decisions. CHE purchased the DataVision™/Core Measures system and the Care Management system, including four sub-system modules: Hospital Case Management, Risk Management, Quality/Outcomes Management and Infection Control.

Five core clinical teams were created—one for each system/sub-system that CHE would implement. Each hospital is represented on each clinical team. These five teams were tasked with developing a high-level project plan for their clinical area, which included a current state assessment, future state model design, gap analysis, transformation plan, building, training and testing plans.

“First, we identified what the CHE future state model should be,” said Lana

MIDAS+ Care Management (TEST AREA) - [NICM Certification Entry - Daugherty, Elizabeth A 12/16/2008 1:52 PM Inpatient]

File Edit View Function SmartMenu Tools Window Help

Name: Daugherty, Elizabeth A Birth Date: [ ] Sex: F MRN: 446593

Facility: [ ] Account No: 112641782 Start Date: 12/16/2008 Start Time: 1:52 PM

Admitting Phys: Meg, Joel Location: SEST Room: 613-613 End Date: 12/24/2008 End Time: 6:19 PM

Attending Phys: Meg, Joel Principal Payer: MEDICARE PARTS A AND B LOS: 0

Payer: MEDICARE PARTS A AND B

Details For MEDICARE PARTS A AND B

Basic Payer Detail

Payer Status: PRINCIPAL Process Date: [ ]

Authorization No.: NFR Service Start: 5/1/1996

Insurance No.: 096247305A Service End: [ ]

Certifications						
Start Date	End Date	# Days	Type	Status	Auth. No.	Ref. No.
12/16/2008	12/24/2008	8	SEST	PRINCIPAL	NFR	

Pictured above (on pages 10 & 11) are examples of the Certification Entry screen in the MIDAS+ Care Management system. Listed below the highlighted payer is the “Details” section of the screen. Within the Details section there are two tabs; Basic and Payer Detail. Each tab contains a set of fields. Below the tabbed section of the screen is a Comments field.

Cabral, R.N., B.S.N., M.S.M., MIDAS+ implementation project director. “This allowed us to begin to develop and design a system that would elevate and enhance our practices.”

Use of the MIDAS+ DataVision™/Core Measures system began in December 2008 at 14 CHE acute care hospitals†. The Infection Control sub-system was also implemented at St. Mary Medical Center and the Mercy Health System of Southeastern Pennsylvania hospitals, in accordance with Pa Act 52 (The Health Care-Associated Infection Prevention and Control Act)‡.

“We decided to roll out one module at a time for all of the hospitals, to allow for group work to happen at the same time,” said Cabral.

## DataVision™/Core Measures

The MIDAS+ DataVision system offers a full spectrum of data management services that allows the user to evaluate and benchmark hospital performance. Users can track and analyze clinical, utilization and provider practice patterns, evaluate high-risk

populations and meet regulatory reporting requirements.

The Core Measures component provides over 150 fully automated outcome measures and a full range of process measures that can be used to trend hospital performance over time and benchmark performance against hospitals within CHE and nationwide. Plus, it generates comparative, severity-adjusted outcome data.

“The DataVision system with the Core Measures component will help us to understand where opportunities and best practices exist throughout CHE,” said Cabral.

## Hospital Case Management

Hospital case management (HCM) is a process for evaluating medical care efficiency. The case manager identifies appropriate levels of care and considers alternative therapies and resource usage. To measure improvement in medical care efficiency, the practitioner presents care providers with specific opportunities to improve and monitors their progress over time.



# Meeting Core Measures Requirements and Reporting Across CHE

MIDAS+ Care Management (TEST AREA) - [HCM Certification Entry - Daugherty, Elizabeth A 12/16/2008 1:52 PM Inpatient]

Name: Daugherty, Elizabeth A Birth Date: Sex: F MRN: 446593

Facility: Account No: 112641782 Start Date: 12/16/2008 Start Time: 1:52 PM

Admitting Phys: Megh, Joel Location: EAST Room: 613-513 End Date: 12/24/2008 End Time: 6:19 PM

Attending Phys: Megh, Joel Principal Payer: MEDICARE PARTS A AND B LOS: B

Payer: MEDICARE PARTS A AND B

Details for MEDICARE PARTS A AND B

Basic Payer Detail

Group ID: Subscriber: DAUGHERTY, Elizabeth A

Reimbursement Type: SEN:

Coverage Option: Relationship: Self/same as patient

MEDICARE PARTS A AND B Comments:

*“CHE and its acute care hospitals must be equipped with effective tools to individually and collectively improve the quality, efficiency and value of health care.”*

**Tom Garthwaite, M.D., executive vice president and chief medical officer, CHE**

The MIDAS+ HCM sub-system provides tools for online documentation, certification, tracking, authorization and discharge planning, transforming the entire process to a paperless one. Case reviewers can quickly scan support service history data in real-time for a patient or health plan member.

## Infection Control

The Infection Control (IC) sub-system is used to document information pertaining to hospital-wide surveillance and hospital-acquired infections. Users can trend infection surveillance results on a monthly, quarterly or annual basis. It provides a crucial function for integrating detailed infection data with the entire MIDAS+ system, including patient demographic data, encounter detail and surgery data. The IC sub-system also provides infection control practitioners with easy-to-manage data analysis and reporting functions.

## Quality/Outcomes Management

The MIDAS+ Quality/Outcomes

Management (Q/OM) sub-system provides CHE with a tool to enhance the efficiency of key hospital performance/quality improvement processes system-wide. It allows for enhanced reporting and data mining in multiple dimensions of care, as well as the development and implementation of “best practices” relevant to quality improvement.

The Q/OM sub-system supports the comprehensive review of quality issues such as clinical complications, unexpected outcomes and medical management issues over time to establish patterns and trends. Specific areas of quality concern such as transfusions, critical care, drug usage, obstetrics and neonatal care are addressed in separate functions, each with the ability to create user-defined fields for supplemental data collection.

## Risk Management

One of CHE’s goals is the development of a more effective and efficient paperless

incident reporting system in order to trend incidents at the RHC level and to improve the quality of patient care.

The online MIDAS+ Risk Management (RM) sub-system automates and streamlines the incident reporting process by giving colleagues the ability to report incidents electronically and allows risk managers the ability to receive real-time incident reports and data.

Remote Data Entry (RDE) for event reporting is accessible through the hospital intranet to increase reporting and decrease the time between incidents and their entry into the database. Users design the RDE entry forms to suit any incident type. The RDE application is entry only and it is immediately available in the MIDAS+ database for review, referral and reporting. User-defined rules and e-mail notifications automate follow-up and manage workflow and referrals.

CHE is nearly a year-and-a-half into the two-year MIDAS+ project. The next implementation wave is Hospital Case Management, which is scheduled for June 2009. This will be followed by Risk Management in August 2009 and Quality/Outcomes Management and Infection Control—Phase II (the remaining acute care hospitals) are planned for later in 2009. Saint Michael’s Medical Center, Newark, N.J., is participating in the project planning but will not implement the MIDAS+ system until 2010.

For more information about the MIDAS+ project, please contact Lana Cabral, R.N., B.S.N., M.S.M., Midas+ implementation project director, at [lcabral@che.org](mailto:lcabral@che.org) or 610.355.2178.

† As of April 1, 2009, three additional acute care hospitals (Mercy Medical Center, Springfield, Mass.; Holy Cross Hospital, Ft. Lauderdale, Fla.; and St Mary’s Health Care System, Athens, Ga.) have gone live with the DataVision™/Core Measures system. St. Peter’s Hospital, Albany, N.Y., is scheduled to go live in October 2009.

‡ Marian Community Hospital (Maxis Health System) in Carbondale, Pa., was granted a deferral by the state until 2010.



CATHOLIC HEALTH EAST

# Across the System



Mercy Medical recently welcomed its new CEO and president, Jake Bell with a special blessing and reception at the Mercy Rehabilitation Hospital, located in Daphne, Ala. During the ceremony, the Mercy Medical mission statement, values, Ethical and Religious Directives Booklet, Spiritual and Corporal Works of Mercy, the Mercy Cross, the Values in Practice staff handbook, the staff directory and the history of the Sisters of Mercy Pictorial Books were given by different staff members to Bell, while a prayer for each gift was offered.



The Nursing Quality Council of Sisters of Providence Health System's Mercy Medical Center recently marked the success of the facility's vaccine initiative with a celebration themed "nursing call the shots." Pictured (left to right) are Brenda Pilachowski, R.N., Michelle Fleury, R.N. and Joanne Powell, R.N.



Saint Joseph's Hospital, Atlanta, Ga., received its third redesignation from the American Nurses Credentialing Center (ANCC) Magnet Recognition Program® in March 2009. Saint Joseph's Hospital is one of only two hospitals in the nation to achieve Magnet status four times. Magnet recognition is a prestigious distinction which recognizes hospitals for excellence in nursing care. Less than 6 percent of all health care organizations in the U.S. have achieved Magnet recognition. Congratulations to all Saint Joseph's nurses and team members for this nationally prestigious achievement.



Nazareth Hospital physical therapist Jason Barnette helps a native of Kingston, Jamaica, during a 10-day medical mission trip sponsored by CHE's Global Health Ministry. "It was the experience of a lifetime. It changed me in ways I didn't expect," said Jason.



The physical therapy department was a popular stop along a second grade class's recent tour of St. James Mercy Hospital in Hornell, N.Y. The equipment got a real workout!



CATHOLIC HEALTH EAST

Every Tuesday morning, Marian Community Hospital volunteer Sandra Anderson sings and plays traditional gospel music on both keyboard and guitar in the hospital chapel. The music is televised into patient rooms via closed circuit television. Staff members and visitors are also encouraged to visit the chapel for private prayer and personal reflection during this time.

Marian Community Hospital is a part of Maxis Health System in Carbondale, Pa.



Catholic Health

Sisters of Charity Hospital

St. Joseph Campus



**Transfer of St. Joseph Hospital (CHS) Sponsorship**

Sometimes the Holy Spirit works through unusual means. The New York State commission that called for the closing of St. Joseph Hospital in Cheektowaga, N.Y., member of Catholic Health (CHS), Buffalo, N.Y., led to profound discernment for one of CHE's founding Sponsors. An agreement with the state of New York that would preserve St. Joseph Hospital included recognizing it as a satellite of the Daughters' hospital in Buffalo, raising issues of sponsorship of the ministry. With prayer, courage and sorrow, the Franciscan Sisters of St. Joseph decided that the time was right for a transfer of sponsorship of St. Joseph Hospital.

In that process, the other Sponsors of CHS—the Daughters of Charity, the Sisters of Mercy of the Americas, New York, Pennsylvania, Pacific West Community, and the Diocese of Buffalo—made a commitment to co-sponsor the health system. This has been approved by the Vatican and CHS is now a co-sponsored entity. Effective April 1, 2009, St. Joseph Hospital is **Sisters of Charity Hospital, St. Joseph Campus**. While we have had several Sponsors join CHE, this is the first Sponsor who will leave CHE. It is a poignant moment, but one which demonstrates continuation of a cherished ministry.

St. Mary Medical Center (Langhorne, Pa.) celebrated the 90th birthday of Sister James McGlashen in January. Sister James, who lives in the St. Mary Convent on the grounds of the Medical Center, is a volunteer for the health information management (HIM) department. St. Mary colleagues from HIM, spiritual care and other departments joined in the festivities.



CHE recently welcomed Kimberly Lansford as the new vice president of compliance and internal audit. Kim previously served as vice president and chief compliance officer at Saint Joseph's Health System, Inc., Atlanta, Ga.



We bid farewell to Diane Denny, CHE's vice president of quality and patient safety since 2000, who is leaving to pursue other interests. Diane has provided outstanding leadership and service, most notably in developing and championing the Values in Practice initiative, leading CHE's efforts in the Institute for Healthcare Improvement's 100,000 Lives/5 Million Lives Campaigns and overseeing efforts to improve our clinical quality performance. She has facilitated CHE clinical collaboratives, multiple quality and safety councils and three Joint Commission survey cycles. Please join us in thanking Diane for her years of service and wishing her best of luck in all future endeavors.



Congratulations to Anna Marie Butrie, recently appointed as CHE's vice president for strategy management and operations improvement. Anna Marie has served as vice president of operations improvement since 2003. In her expanded role, she will direct the strategic management process for CHE, assist System and regional leadership in strategy formation and service development, and serve as a resource in the identification and creation of strategic linkages and relationships.



CHE welcomes Scott Ash, who was recently appointed to the newly created position of vice president, business development. In this role he will identify, develop and implement new system level business opportunities. Scott was previously a partner in TRG Healthcare, LLC, a consulting firm with offices in Philadelphia and Southfield, Mich.



# Advocacy and Wellness: A Winning Combination

**O**n Monday, February 9, Alexander J. Hatala, president and CEO of Catholic Health East New Jersey and Lourdes Health System, joined CHE-NJ hospital CEOs and members of the CHE-NJ advocacy team to host a legislative reception at the State House in Trenton.

"We certainly were able to make the point that 'Together we are so much more', especially as it relates to our partnership with the state and the critical importance of fair charity care funding for our urban hospitals," said Hatala.

Designed to introduce CHE-NJ to elected and appointed officials, the event drew 25 legislators, including Senate President Richard J. Codey and Assembly Speaker Joseph J. Roberts, Jr. Other participants included Heather Howard, commissioner of the N.J. Department of Health and Senior Services, and Edward McBride, chief of staff to Governor Jon S. Corzine. All in attendance had the opportunity to take advantage of blood pressure and glucose screenings, provided courtesy of the Lourdes Wellness Center.

"This event gave us a great chance to start making our case to legislators and officials in advance of Fiscal Year 2010 State Budget votes," explained Jim Wallace, CHE-NJ vice president, government affairs.

Promoting improved access to top-quality health care for all New Jerseyans, CHE-NJ is asking lawmakers to recognize the important role of safety net hospitals, to consider prudent plans for health care reform, to safeguard non-profit hospitals from potential threats posed by the conversion of community health resources to for-profit status, and to ensure fair funding of Medicaid and charity care.

"With our collective service area extending from Greater Camden to Greater Newark, CHE-NJ has a unique 'statewide' perspective on the challenges



*The Lourdes event was attended by 25 key legislative and government officials. Pictured from left to right: Alexander J. Hatala, CHE-NJ president and CEO; Assemblyman Joseph J. Roberts, Jr., Speaker of the New Jersey State Assembly; New Jersey Commissioner of Health and Senior Services Heather Howard; and Senator Richard Codey, President of the New Jersey State Senate.*

hospital now face," said Hatala. "We want to make sure our legislators understand that CHE-NJ's future will depend in large part on adequate charity care appropriations and on fair and equitable reimbursements."

"In 2009, the cost for CHE-NJ hospitals to provide charity care is projected to grow to \$86.2 million, valued at Medicaid rates," continued Hatala, "while charity care reimbursements are expected to remain at \$47.5 million. This anticipated \$38.7 million gap will mean CHE-NJ affiliates—like most New Jersey hospitals—can expect to continue struggling. We need legislators' help to close that gap."

The CHE-NJ hospitals—Lourdes Medical Center of Burlington County in Willingboro, Our Lady of Lourdes Medical Center in Camden, St. Francis Medical Center in Trenton, and Saint Michael's Medical Center in Newark—will care for more than 600,000 patients in 2009. These patients will come from 15 of New

Jersey's 21 counties and from 27 of the state's 40 legislative districts.

"The CEOs of our four hospitals—Eugene Johnson, Mark Bateman, Jerry Jablonowski and Rob Evans—were on hand to help spread the word about CHE-NJ and our unified advocacy efforts," said Wallace. "Together, we will continue speaking for our four hospitals and the people they serve, and we expect to be heard loudly and clearly."

According to Ken Becker, CHE's vice president of government relations, advocacy and fund development, "CHE-NJ's Trenton legislative event is a great example of how powerfully our message can be delivered and our presence felt when we come together and collaborate as a system. This event would not have been as successful nor gotten the attention of as many key stakeholders if it had been orchestrated by a single stand-alone hospital. This demonstrates the enhanced ability of our health system to become an even stronger voice for our ministries and the communities and patients we serve." 

# ACT: Advancing Clinical Transformation

*Launched in 2009, the ACT (Advancing Clinical Transformation) initiative's key objective is to identify, analyze and implement clinical transformation opportunities that result in superb clinical outcomes and enhance quality and patient safety across the system. Recognizing the complexity of this initiative, it was imperative to find an effective way to tap the expertise, experience and creativity of our clinical and operational colleagues ... encourage open dialogue and input ... and enhance and expedite decision-making processes.*

Each RHC will assess and then set its own targets for improving clinical performance. Supporting the RHC effort is the CHE Council structure; each Council has been charged to review specific items, e.g. CFO Council will review net revenue/adjusted discharge CMI; Comprehensive Care Management Council will review Medicare length of stay, acute care readmissions within 30 days, clinical denials, etc.

One critical step taken to date has been the decision to focus on several key hospital-acquired conditions as a way to effect clinical transformation throughout the entire health system. The Patient Care Executive Committee, comprised of the top patient care executives from each RHC, met recently to discuss and begin to set targets for reducing/eliminating the following five hospital-acquired conditions:

- Catheter-associated urinary tract infections
- Falls resulting in injury
- Central line infections
- Ventilator-associated pneumonia
- Stages II, III and IV, deep tissue injury and unstageable pressure ulcers

"The Patient Care Executives are energized and excited by the opportunity to participate in the ACT initiative," says Judy Persichilli, CHE's executive vice president, acute care. "They are committed to advancing clinical transformation and promoting safer, high quality care by eliminating hospital-acquired conditions."

influences that these changes are having throughout the continuum of care."

Our enhanced focus on transforming clinical processes and improving quality and patient safety is consistent with our Mission, Vision and Core Values. Our collective work product will also result in financial savings across the system that are critically important to bridging the



RHC chief executive officers voiced their support for the initiative and its importance to CHE's future during a recent web cast.

"As health care leaders it is incumbent upon us to forge the way, bringing the delivery of health care to a higher level in which every person we treat experiences safe and high quality care," says Steve Boyle, president and chief executive officer, St. Peter's Health Care Services, Albany, N.Y.

"The continuing care group will closely parallel the acute care group in identifying and benchmarking clinical and operational metrics specific to our various ministries," says Ken Cormier, president and chief executive officer, St. Joseph of the Pines, Southern Pines, N.C. "In addition, a very important part of the ACT initiative will be to evaluate opportunities for growth in our ministries, focusing on the changing demographics of our society and the

gap between our current health care system and where we hope to be: a person-centered system by the year 2017.

One of the major initial goals of the ACT initiative is referred to as "100/100": the imperative to develop a plan to save \$100 million dollars in the first 100 days of 2009. These cost-savings can begin to be implemented in 2009, and must be implemented by 2010. These savings (or revenue growth), which are over and above the approved 2009 budget, will be realized through a combination of clinical transformation, improving selected operational activities, modifications in strategy in selected RHCs, and growth in continuing care services.

Action plans for all initiatives will be finalized by May 1, 2009, with implementation of initiatives beginning immediately thereafter and continuing through 2010.



# 10 Minutes with... Clayton Fitzhugh

**P**rior to joining the Catholic Health East (CHE) System Office in June 2007, Clayton Fitzhugh served as senior vice president of human resources and operational performance for Holy Cross Hospital (Fort Lauderdale, Fla.), a CHE member. He has nearly 25 years experience in human resources and quality management. Clayton graduated from Hyles-Anderson College in Crown Point, Indiana. He also served two terms as a member of the Board of Examiners for the Malcolm Baldrige National Quality Award.

## What attracted you to Catholic Health East? And why did you decide to transition to the System Office?

First and foremost was an inner, higher calling to use my life in service for others. What attracted me to the System Office was the opportunity to have an even broader impact on our ministry and in fulfilling our Mission. I so appreciated my time at Holy Cross as it helped prepare me for my role at the System Office. For example, it helped me to understand how the decisions at the System Office impact the day-to-day operations at the RHCs. Before we ask the RHCs to do something, we have to question the value proposition of the request. Will it help us with some "nice-to-know" information or will it truly add value in helping the RHCs respond to their markets with limited resources? We are here to serve the RHCs; they serve the poor and those most vulnerable in their communities.

## What are some of your accomplishments since you have been with CHE?

Well, I would like to highlight some of the accomplishments of the HR Council and the



Clayton Fitzhugh,  
Vice President and  
Chief Human Resources Officer

System Office HR team. The HR Council reworked the 2017 Strategic Plan (People Pillar). They did a nice job of bringing balance to the plan by focusing on CHE and related RHCs being great places to work, and also creating the expectation that we must deliver great results. While we want to be a great place to work and practice our craft, we also expect great results; goals are met and targets are achieved. The HR Council members have also broadened our view from one that focused primarily on their independent RHC, to one that realizes that our opportunity and future are system related. In other words, "together we are so much more" has become more of our call to action than just a tag line.

In addition, the System Office HR team continues to amaze me with their tenacity and professionalism. For example, in addition to working for the 400 plus System Office colleagues, we are responsible for over 30,000 payroll instruments per month (soon to be over 50,000); we are responsible for managing and coordinating

pharmacy and volunteer benefits for over 40,000 people; and we are responsible for pension and other retirement programs with collective value approaching \$400 million. They continue to develop and redesign processes that allow for excellent service in meeting the needs and expectations of our customers (who happen to be our employees). The HR Council and the System Office HR team are doing a terrific job.

## What are your immediate priorities/goals for your department?

Our focus is on making the HR Strategic Plan a reality. To help facilitate this, we are continuing to drive the Leadership Development agenda (we are investing in leaders), broaden the training and development opportunities for all colleagues, leverage "systemness" initiatives, and roll-out our "Culture of Inclusion" effort. I am very excited about our Culture of Inclusion plan.

## What are some of the recent trends in HR? And what are the biggest challenges, especially during this economic 'crunch'?

All of our colleagues understand what is happening with the economy and they want to know if and how it will impact CHE and our RHCs. Therefore, we remain busy trying to understand and implement legislation and regulatory changes that potentially impact us. For example, the recent stimulus package calls for changes in how COBRA (extended benefits) is administered and whether or not it actually applies to not-for-profit ministries. While we keep an eye on these types of changes, we also need to be busy about helping our various ministries reach our operating targets. We need to help create an environment that allows for us to deliver quality outcomes in a cost effective manner. Our primary goal is to continue the ministry of our Sponsors and serve the poor and vulnerable in the communities we serve.

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Locations: Located in 11 eastern states from Maine to Florida.

Workforce: Approx. 54,000 employees.

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