Hospital Evidence-Based Medicine Workgroup (Low-Hanging Fruit Group)
3/13/09—Third Conference Call Notes

Participants: Chip Davis, Barbara Epke, Bill Minogue, James Chesley, Jill Berger, Kathi White, Robin Newhouse, Howard Carolan, I-Fong Sun, Dianne Feeney, Pam Barclay, Maria Prince, Gwen Winston, Nicole Stallings, Orion Courtin, and Mary Mussman.

The call centered on preparation for the workgroup's presentation to the full Council on March 20, 2009. Chip Davis will not be able to attend, but another Council member, Barbara Epke, has agreed to do the presentation. The call participants discussed the various initiatives again, prioritized them with a proposed phase-in order, and discussed implementation methodology further.

First priority remains the Hand Hygiene Campaign tied to Hospital Acquired Infection-Focused Checklists. Chip reported that the World Health Organization (WHO) announced a global hand washing campaign that seeks to enroll 5,000 volunteer hospitals internationally. We discussed whether Maryland might be the first statewide hospital network to sign on to the WHO project.

We discussed outcomes for hand hygiene and decided to shoot for 100% adoption and transparency. We discussed possible compliance measures: self-reporting of hand washing, "secret shopper" observation, UV light examination of the hands, and patient reporting on physician behavior. Dr. Chesley mentioned a 3 minute video in English and Spanish to explain to patients why and how to report hand washing by their providers. Once we have hand washing compliance data there are several options for how to use it. We discussed optional reporting by hospital to start, with a "preview" phase before reporting was made public. The group felt that establishing a start date for adoption of the initiative statewide was important, and that the fact that all the hospitals have signed on to the NHSN program from CDC is a first step. The goal being to eventually put information on the web and reach consensus among the hospitals regarding its utility.

The group felt that a quick turn-around collaborative might be the best way to decide the start date, campaign elements, compliance monitoring, and reporting. Longer term, the linkage with actual hospital acquired infection rates in Maryland could be reported. In summary, the group recommends gathering the experts and hospital representatives to set the standards for the hand hygiene and infection related checklists initiative.

Second priority is Door to Balloon Time. This initiative would focus on process improvement within hospitals and sharing best practices, including the transmission of 12-lead ECG information from the EMTs in the field to the Emergency Departments in order to speed up preparation of the catheterization lab/team for the patient's arrival. This initiative would not focus on realignment of transport protocols. Data about door to balloon time would be captured in a standard way across hospitals with open-heart or primary PCI capability. The group felt the best way to approach the development of the standards for this initiative is also the short-term collaborative approach; to engage existing groups, including MIEMSS, and help coordinate statewide efforts to improve STEMI response time through a combination of high-tech and low-tech improvements in care.

Third priority for projects that could be addressed immediately is the Prevention of Blood Wastage project, which could use Lean Sigma as the methodology. Chip suggested we could survey hospitals to learn whether there was a concern in this area. This initiative is one that many workgroup members like because it has a public health benefit of saving a scarce resource and affects all hospitals, unlike Door to Balloon Time, which is limited to about half of the hospitals.

Longer term priorities were discussed and prioritized as well, with stroke telemedicine first in this category. It was reported that certain parts of the state have already had great success in this area and have treated many stroke patients in an ideal way that has also resulted in significant savings of hospital and taxpayer money. The group discussed approaching this initiative in a similar way to the above, with a quick turn-around collaborative to establish statewide standards and processes. The second long term project would be development of a HIPAA standardized transaction set for patient eligibility and preauthorization for service. The final area of interest would be to work on the discharge bundle of services to reduce hospital readmission rates.

These ideas will be presented to the full Quality and Cost Council on Friday, March 20, 2009, from 9:30-12:00 at the UMBC Tech Center. For more information check the website: http://dhmh.state.md.us/mhqcc/meetings.html