

TRENDS & Ideas

LONG-TERM CARE

A Bank for Innovations

Long-term care administrators will soon have a wealth of good ideas at their fingertips on the Internet. A coalition of provider, consumer, and professional groups; states; and the Health Care Financing Administration (HCFA) is creating a repository of innovative practices that promote high-quality care and improved quality of life for nursing home residents.

The group, of which the Catholic Health Association (CHA) is a member, is soliciting submissions from nursing homes in the following areas: caring for special populations; clinical practice guidelines for infection control, pressure sores, incontinence, and restorative care; new advances; fall prevention; caring for dying residents; pain con-



trol; optimizing use of staff; creating a culture of trust; environmental enhancements; and resident's personal belongings. CHA will accept submissions and forward them to the coalition for evaluation, said Karen Schoeneman, director of the Sharing Innovations in Quality project, at a recent CHA meeting for directors of aging services.

To learn more about the project and how to submit an idea, visit the Sharing Innovations in Quality web site at www.hcfa.gov/medicaid/qualhmpg.htm. You may also contact HCFA's Julie Moyers at

jmoyers@hcfa.gov, or CHA's Julie Trocchio at jtrocch@chausa.org or 202-296-2993.

DEATH AND DYING

Where We Die

Geography is, in part, destiny, according to the results of a new study conducted by medical researchers at Dartmouth Medical School. The

study shows that, despite the fact that most people would prefer to die at home or in a hospice, where they die depends greatly on

where they live. Residents of the East Coast, the Southeast, and some large cities are more likely to die in hospitals and spend time in

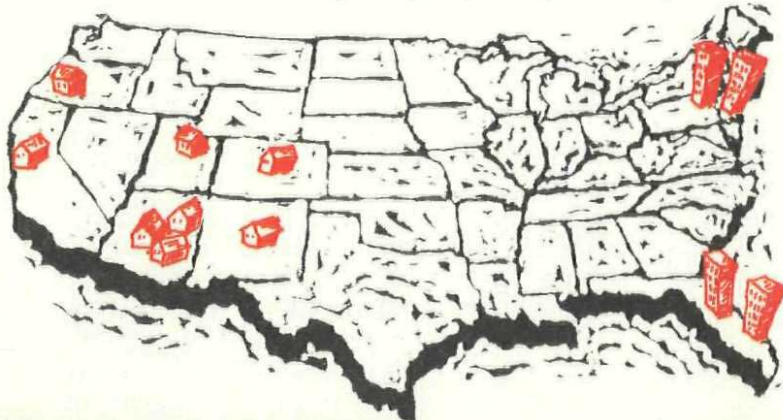
intensive care units than those who live on the West Coast.

The study's findings are based on an analysis of the deaths of Medicare patients in 1994 and 1995. They show wide regional discrepancies between the number of days spent in the hospital during the last six months of life, the percentage of patients who were in the hospital at the time of death, and the chance of being in a hospital intensive care unit at the time of death. These variations occur, according

to the study's authors, "even though there is no evidence that residents tend to be sicker or to live any longer in the places where patients receive the most care."

"Where dying patients end up is a factor of physician preferences and availability of hospital beds and intensive care units," said John E. Wennberg, MD, the principal author of the study. "I don't believe most people would prefer to die in a hospital ICU, but in many cities in the United States, they do."

Sim Gellman



Stopping Surgical Wake-Ups



A technological solution to every surgery patient's worst nightmare—waking up during surgery, feeling the pain of the procedure, and yet being unable to speak, or even open one's eyes—may be on the horizon, writes James Willwerth in *Time*. The Bispectral Index Monitor, a system that monitors patients' brain waves, is designed to reduce or even eliminate surgical wake-ups.

Called "awakenings" by anesthesiologists, surgical wake-ups may occur in as many as 40,000 of the 20 million surgeries performed annually in this country. In most cases the painkillers continue working, and the patient feels only uncomfortable pressure. In other cases the pain breaks through, but

the patient, due to the paralytic drugs administered along with anesthesia, is helpless. Experts estimate that such cases could number in the thousands.

Symptoms of post-traumatic stress disorder, including flashbacks, irrational fears, and severe insomnia, plague many patients who suffer wake-ups. One researcher had trouble recruiting survivors for research on awakenings because many refused to enter the hospital to meet with her. Few survivors of the experience tell their anesthesiologists, who consequently have little or no idea how their patients suffer.

The new index monitor may enable anesthesiologists to detect wake-ups. The device, about the size of a

Redesign Cuts Length of Stay

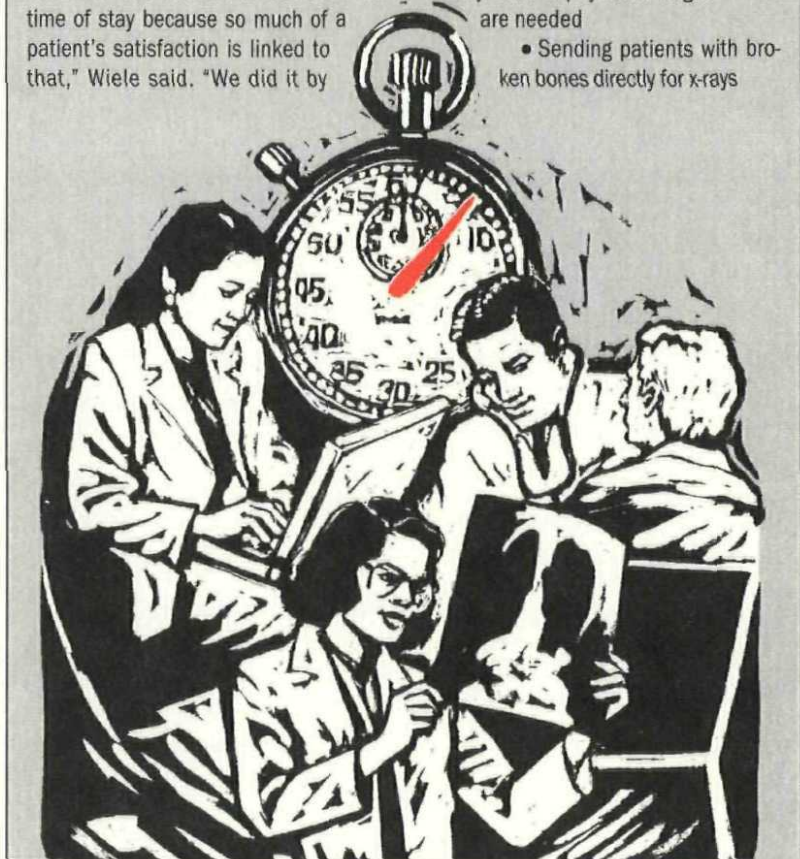
SSM St. Mary's Health Center, St. Louis, has reduced the average patient length of stay in its emergency room by 45 percent, write William Flannery and Tim O'Neil in the *St. Louis Post-Dispatch*. The achievement is the result of an emergency room redesign, which recently earned the hospital a Missouri Quality Award.

In 1996 the average length of stay was 220 minutes, said Dr. Robert Wiele, codirector of the emergency room. The redesign cut the average length to 90 minutes. "We wanted to decrease the time of stay because so much of a patient's satisfaction is linked to that," Wiele said. "We did it by

looking at all the small things."

Teams of physicians, nurses, technicians, and business personnel combined to develop a system in which tasks could be done more or less concurrently, Wiele said. Among the changes made were:

- Taking patients immediately to the treatment room, where clerks type insurance information into a laptop computer at the same time treatment begins
- Drawing blood on a nurse's recommendation so that it will be available for any tests a physician might decide are needed
- Sending patients with broken bones directly for x-rays



toaster oven, is a specialized EEG machine that translates the patient's brain waves into a single number that the operating room team can then watch to make sure

it stays in the acceptable range. This method promises to be a more accurate means of gauging sleep level than the traditional monitoring of blood pressure

and other vital signs.

The device has been approved by the FDA and is already placed in several hundred systems across the country.