caregiverconnection

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news for the caregivers at st. charles medical center - bend and st. charles medical center - redmond

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Home Health: Making Changes, Moving Forward

St. Charles Home Health has a "Renewed Commitment"

For many SCMC patients, the sound of a doorbell means that compassionate care is on its way—beginning with a St. Charles Home Health caregiver on their doorstep. It's how over 2,400 patients in Central Oregon (2,000 of which are new patients for 2006) have received individual care so far this year. Some 90 caregivers are involved in the St. Charles Home Health program, and in addition to in-home nursing care, other home health services include physical, occupational, and speech therapies, as well as medical social work and home health aide services.

SCMC has owned the program since 1984, though its inception can be traced back as far as 1966, when it was operated by county health departments. Over the years, Central Oregonians of all ages, from babies to geriatric patients, have benefited from this special mode of care.

Home Health aide Barb McVay visits with a patient.

But six years ago the field of home health—locally and nationally—shifted rather suddenly when Medicare changed the way it reimbursed for services (like many similar programs, St. Charles Home Health is funded largely by Medicare). As a result, a per-visit fee system was changed to a per-case fee system. Essentially it meant that fixed amounts were set up per individual case. It closed the doors to many home health agencies across the country as they struggled to adapt to the new system.

St. Charles Home Health has had its own share of financial struggles, weathering some operational losses in the past few years. In addition to the Medicare changes, converting to electronic medical records and facing higher operating costs have both been factors. Rumors began to circulate that Home Health might not continue.

So this past April, to help address financial performance and guide the program successfully into the years ahead, CHC brought in consultants from The Corridor Group, a Kansas-based home care specialist. After assessing the program, Corridor outlined St. Charles Home Health's strengths, weaknesses, opportunities, and risks. Their recommendations focused on office and field staff processes and productivity, as well as inter-connectedness of clinical and financial indicators. They also made suggestions for long-term organizational viability.

"As a result, we developed an action plan," said Clinical Services Manager Debbie Robinson, RN. "And all Home Health staff have been involved with defining the issues and then implementing the needed changes. Our action plan is a 'working' document and hospital administration is given weekly updates on our progress."

Part of this progress has involved a structured marketing plan that identifies certain groups of patients and referral sources to assist in the growth and viability of the agency. "Our current focus is strengthening our core business," said Robinson. "And we'll look at expanding other services as the need arises."

Additionally, when longtime Home Health administrator Jerrie Melton left the organization several months

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Caregiver Connection is the monthly employee newsletter for caregivers at St. Charles Medical Center - Bend and St. Charles Medical Center - Redmond.

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In the Shadow of Hurricane Katrina: The Healing Continues

A Report from New Orleans | By Mark R. Johnson, Caregiver Connection's departing editor

It wasn't very hard to imagine people crowded on the roof of the hospital, staring in desperation at the high waters and praying for their rescue—you can still a few chairs up there, arranged at odd angles, weathering away in the Louisiana sun.

For flood victims of Hurricane Katrina, high and dry was the only thing that made any sense when the levees broke and the waters climbed. And in New Orleans' St. Bernard Parish, about 20 miles southeast of the city, where almost every building in the entire Parish would eventually be flooded, many people seeking to get above the water flocked to Chalmette Medical Center, an acute care, 170-bed facility. A place filled with doctors and nurses was a logical refuge in a catastrophic situation; equally alluring was the height of the building.

Apparently, patients and staff had trouble evacuating because there were simply so many people seeking safety on the roof and hovering helicopters had nowhere to touch down. The irony must have frustrated countless helicopter pilots.

Staring at the hospital, my wife and I felt like we were seeing a scene torn from a war zone. **We'd gotten accustomed to seeing homes in all stages of havoc, but seeing a hospital laid to waste was something altogether different. A hospital serves as a cornerstone of a community—this one had been ravaged and abandoned.**

It was the week leading up to Christmas and we were spending some time volunteering with the St. Bernard Project, a nonprofit organization that's helping homeowners rebuild their gutted homes. We stayed in a former elementary school that's been reinvented as a volunteer's camp and every day we went off in small platoons to hang drywall or haul out appliances that held some pretty foul smells. Cockroaches were having a heyday.

One morning while trying to locate an address, and dodging a few crater-sized potholes en route, we took a wrong turn and ended up driving past the hospital. It was a tough image to shake.

Exit wound: Not your typical view of an American hospital.

A hurricane-wrenched sign announces the condition of Chalmette Medical Center.

Maybe it was because of the sheer devastation to the structure—so punctured with holes and flanked with debris. One end actually had a gaping hole big enough to drive a truck through (which is probably what they used it for in the clean-out process). Or maybe it was because a year and half has gone by and the building looks as if it's been preserved in its very hour of mayhem, a reminder of how bad things became.

And there was a quick reflex to think of home. The population of St. Bernard, after all, used to be about 65,000 (it's about half that now), similar to Bend's. And the medical center is (was) a little smaller than SCMC-Bend, but close enough. Anyway, I couldn't get the images out of my head and we returned later with a camera.

There are some health clinics serving the local residents but healthcare as a whole has taken a major hit—only half of the New Orleans area hospitals are back in operation. With a massive downshift in the New Orleans population (less than half of its 455,000 residents have returned) many professionals—including those in the healthcare field—have moved on out of sheer necessity. It's something that's been bluntly dubbed the "brain drain."

Living there means waking up to a daily reminder of the storm. Streets are lined with FEMA trailers parked in front yards. Houses are still tattooed with big "X's" that rescuers hastily made in neon spray-paint: the numbers around the X refer to the date, the rescue team, the number of dogs found, and the number of bodies found.

You can still see debris piled on rooftops looking like beaches littered after a high tide. And all of the storm stories are incredible.

One resident told me that by the time he got from the curb at the front of a house to the front door—to help an elderly relative into a boat—the water had caught up with him, matching his pace. He said they hopped in the skiff and rode out the storm tied to a pole on the property, while across the street a neighbor bobbed in a tire throughout the ordeal. "You mean an inner tube?" I asked. "No, a tie-uhh," he reiterated, his drawl harping on the absurdity of the image.

The place is struggling hard with its rebirth. Media reports are now focusing on the sudden upswing in violence, the recent march on City Hall by fed-up residents, and the lackluster French Quarter, where the music and street-party vibe continues to flavor the city but with decidedly less verve. The New Orleans Saints—up until recently—were truly carrying more than their share of postseason hopes and dreams on their shoulders.

Still, despite the obvious struggles, we were impressed with a great deal of what we saw. Many people are rebuilding, trying to get back to their lives, and obviously hoping the new levees are bigger and better (and run deeper) than before. There are legions of volunteers—everyone from students to retirees to a guy we met who left his architecture firm to volunteer indefinitely—who have descended on the area to help. But many more are needed.

Residents are extremely grateful for the help. They show their Southern hospitality with food and the occasional big hug thrown in. "You just being here means something to them," a relief worker told a roomful of us. There's definitely a lot of talk-therapy that goes on.

We hope to get back to the St. Bernard Parish someday. By the looks of things, it'll likely be decades before a sense of normalcy is regained. Hopefully a new hospital or two will come sooner than that.

News for Physicians of St. Charles Medical Center - Bend,
St. Charles Medical Center - Redmond, and their CONet colleagues

St. Charles MEDICAL CENTER BEND • REDMOND

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Progress notes

Issue 5 May 2005

This Month In Healthcare

HIPAA Security Regulation

Prior to the HIPAA Privacy and Security regulation, there was no standardization of requirements for protecting health information. The HIPAA Privacy rule was beneficial in setting standards for many things, including identifying who can access protected health information. The HIPAA Security regulation sets standards for ensuring that only those who should have access to electronic protected health information actually have access.

This federal regulation, which went into effect on April 20, is for covered entities such as Cascade Healthcare Community. The security standards include categories of administrative safeguards, physical safeguards, and technical safeguards. CHC has performed a risk assessment of these categories, identified areas for improvement, and is in the process of building work instructions to address compliance with the regulation. You can be a vital part of this implementation in terms of staying alert to and reporting possible security issues, thereby helping to improve safeguards for our patients' health information. This can be anything from observing unlocked doors that should be locked, to computers left on and made visible when not in use, to the use of cameras in facilities by visitors.

Let the HIPAA team know if there are any potential concerns that could compromise patient privacy. Contact CHC HIPAA/ Compliance at 388-7760.

First Annual Rural Surgery Symposium
May 22-23, 2005
Cooperstown, N.Y.

Jim Bishop, interim administrator at Harney District Hospital, and Stephen Olson, MD, are both scheduled presenters.

Visit www.centerforruralsurgery.org to learn more about the symposium and find links to other resources.

What's the Future of "Frontier" Surgery?

A Burns Physician is Part of a Growing Effort to Reinvigorate Rural Surgical Care

For Stephen Olson, MD, leaving his Bend practice last year to start anew in the town of Burns was the perfect thing to do. Having originally moved to Bend in 1991, in search of a sophisticated surgical community amid a rural setting, Olson, 48, said he later found himself in a place where the rural aspect was quickly vanishing. Plus, he didn't like the frantic, unhealthy pace he found himself working at. "So I decided I wanted to do something different," said the former Bend Memorial Clinic surgeon. "And it's brought a new level of enthusiasm and excitement back to my career."

Stephen Olson, MD

Moving to Burns and beginning a general surgery practice at Harney District Hospital proved to be a catalyst for Olson. But his relocation to a rural area symbolizes something that eclipses Olson's own individual story, something that's relevant on a much larger scale.

"The whole issue of surgical services for the rural American is a huge one," Olson said over tea at SCMC-B last month. Citing a U.S. census that places 60 million people living in rural areas, Olson estimates—using census definitions—that roughly 22 to 24 percent of this country's population is rural-based. "From that perspective, there ought to be about 20 or 25 percent of American surgeons filling surgical roles in those environments," he said. "Turns out, there's only eight or nine percent, and that number has been dropping over the last several decades."

While the situation isn't exactly a new one, it's become exacerbated in modern times. Back in 1938, when Mary Imogene Bassett Hospital in Cooperstown, N.Y., held one of the nation's first rural medicine symposia, focused on delivering and receiving care in such regions, it was keenly aware of the challenges facing rural surgery practices—with surgeons already flocking to cities. And these same issues have only been heightened in the past few decades. Rapidly changing technological advances and challenges stemming from the malpractice insurance environment have helped fuel a trend towards sub-specialization. For urban patients, the scenario is ideal: they have access to highly sub-specialized, very skilled surgeons with lots of equipment. But rural patients aren't being afforded quite the same treatment.

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Reinvigorating Rural Surgical Care; Creating a Rural Surgery Fellowship

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Recently, there's been a widening focus on the fate of rural surgery. In just the last two years, the Bulletin of the American College of Surgeons has published several articles on rural surgical care in this country, and the American College of Surgeons and its board of regents created a subcommittee (of which Stephen Olson is a member) to address the future of rural surgery. Later this month, when the Mithoefer Center for Rural Surgery at Mary Imogene Bassett Hospital hosts the first-ever Rural Surgical Symposium (co-sponsored by the American College of Surgeons), these same issues will again be brought into the spotlight.

The Mithoefer Center has also created a rural surgery fellowship to actively address some of these issues. Olson was its first fellow; he completed his three-month fellowship last year. "When I realized I would probably go to Burns, one of the things they needed there was somebody to do endoscopies," he said. "In my practice here in Bend, we had such good gastroenterologists that, as a general surgeon, I didn't need to do that. Now, it's me." For Olson, in some ways, completing the Cooperstown-based fellowship was like going home. By coincidence, he actually grew up in Cooperstown, where his father had been a general surgeon at Mary Imogene Bassett Hospital. But it was also something of a new beginning. Because, in addition to the medical training he received, Olson began conceptualizing the creation of a post-graduate-level fellowship to be offered here in Oregon. He said that if there's enough support, he would like to develop a sister program at Harney District Hospital. "It would obviously include St. Charles," he said. "This hospital would be an absolutely perfect hospital for a post-graduate-level, rural surgical fellowship experience. It's a high-volume, high-quality community hospital without a surgical residency." Olson hopes to launch the project in collaboration with Portland's Oregon Health & Science University and the hospitals of the Eastern Oregon Rural Surgical Initiative (see sidebar).

The idea would be to make the fellowship available to both young med students and also to physicians like himself, who have had a practice and might relocate to a small community. Of course, giving them proper exposure would require some partnerships—including teaching board-eligible or board-certified surgeons how to do particular advanced cases. "I'm hoping to recruit sub-specialists who are interested in doing some clinics in Burns," Olson said of an effort that he's already begun. A number of colleagues have expressed an interest.

EO RSI

Did you know?

The Eastern Oregon Rural Surgical Initiative (EORSI) is an effort to assess the surgical resources and needs of Harney District Hospital, Blue Mountain Hospital, and Lake District Hospital, to improve the access of quality care to rural patients. It is supported by both SCMC and the American College of Surgeons.

Brian O'Hollaren, MD, and the other physicians at Bend Urology Associates, for instance, have been offering monthly rural clinics in Burns and John Day for some time and are hoping to become involved. "We all have an interest in pursuing this," said O'Hollaren. "[Olson] is a great addition to the community. Once the program gets up and running, we'll start out with small cases and move up to bigger cases if all works well."

The trial period will take several years, Olson estimates. In the meantime, his own role as a surgeon at Harney District Hospital is bringing a new level of care to the area. "There's been a very steady increase in the volume of cases going there," he said. If Olson has his way, that's just the beginning.

To learn more about the rural surgery project, please contact Stephen Olson, MD, at Harney District Hospital: solson@harneydh.com.

Community Pharmacy Opens at SCMC-B

SCMC-B's outpatient pharmacy is finding a new home—and a new name. On Monday, May 2, the "Community Pharmacy" will open in the new ER area, beginning a new era of service.

Immediate changes include a separate drop-off window for prescriptions. Also, a prescription pick-up and patient counseling area will allow more privacy for patients discussing their medications with the pharmacist. And once again, nurses can tube-discharge prescriptions to the pharmacy. Keep in mind that with HIPAA regulations, the patients or their representative must pick up the prescriptions at the pharmacy.

New Community Pharmacy

Hours: Monday through Friday, 9 a.m.-7 p.m.
Saturdays, 10 a.m.-3 p.m.
Closed on Sundays
Direct line is 388-7731
Refill phone line is 383-6802

Although space is still limited, the Community Pharmacy hopes to handle some basic over-the-counter medications. (Other items will be available through the Health & Care Store.) A few widely used, high-priced medications (e.g., Prevacid, Protonix) are now available exclusively through the Community Pharmacy for a reduced co-pay of $9 for a 30-day supply. Prices for inexpensive medications (e.g., Levothroid, HCTZ) are kept at the lowest possible costs.