Concurrent Sessions
Tuesday, September 16th 2008

8:00 – 9:15 AM

Redefining Quality for Team-Based Care Management in Primary Care (601)

David A Dorr, MD MS
Quality measurement can be complex for patients with multiple illnesses. Through a primary care clinic based care management program called Care Management Plus, we have demonstrated improvements in satisfaction, productivity and patient outcomes in the chronically ill. Implementing and maintaining care manager-directed care requires a clinical team and structure that supports practice of evidence-based guidelines and protocols, collaborative interactions with the patient at the center, and health information systems that facilitate clinical processes. Many quality measures (eg, HbA1c levels) capture only one part of the flexible care planning required; however, newer quality models (the Medical Home) evaluate broader aspects of the clinical structure including education, assessment of goals and barriers, access to needed care, satisfaction, and coordination. We discuss the importance of redefining quality measures that include all aspects of the care process affecting patient outcomes.

Electronic Decision Support and Evidence-based Practice to Improve Care for Pressure Ulcer and Fall Risk Patients (602)

Martha (Marti) Satwicz, RN MSN MSBA CPHQ
Using risk prediction tools such as the Morse Fall Scale and the Braden Scale in the electronic health record is a common practice. Trinity Health working with our EHR vendor implemented an electronic notification to the nurse when the patient was found to be at risk. This notification alerted the nurse to the risk score or one of the other triggers for risk along with automatically adding a problem to the patient's problem list. As a further follow-up the nurse is sent a reminder to implement an evidence-based order set. Reports provide data that help with continued improvements in the process and drive work efforts towards improved outcomes. Initial data indicate that approximately 51% of patients were at risk for developing a pressure ulcer and 65% for falling. The presentation will address the development process for the alerts and share data related to process and outcomes.

Delivering the One-Two Punch to Clinical Deterioration in Adult Patients on Medical Surgical Units: The Effects of Implementing Early Warning Systems (603)

Lee Ann Hanna, PhD RN CPHQ

Early Warning Systems consist of Critical Care Outreach Teams (CCOT) and Early Warning Scoring Systems (EWSS). Many organizations have improved patient safety by implementing CCOTs, also known as Rapid Response Teams. CCOTs respond to requests from staff members, based on physiological criteria, to assess and treat patients that may be experiencing clinical deterioration. However, patients on medical surgical units continue to experience unrecognized and/or unreported clinical deterioration. Better systems to detect and communicate clinical deterioration are needed. One such system is the EWSS EWSSs transform the patient's physiological data, using weighted criteria, into aggregate scores. The aggregate scores may be used to categorize clinical deterioration and direct care. Come join us and learn how a large urban tertiary acute care hospital improved clinical outcomes and utilization of organizational resources by delivering the one-two punch (CCOT and EWSS) to clinical deterioration in adult patients on medical surgical units.

Partnering in Difficult Discussions (604)

Paulette DiAngi, PhD RN CPHQ

Research strongly suggests that patients are the least forgiving regarding unexpected results when the healthcare providers behave badly and inadvertently destroy the trust in the patient-provider relationship. Disclosure of unanticipated outcomes is required by JCAHO, AMA, and ACP and supported by many other groups; however, it is an easily dismissed service recovery effort. The patient wants to know what happened, to hear that someone is sorry, and to be assured that the hospital is doing all it can to prevent a re-occurrence. They do not want to think their suffering was in vain. Physicians often believe that an apology is an expression of guilt and therefore liability and responsibility. However, the appropriately structured apology does not imply or lead to liability and helping a physician understand that, can allow them to reach out to the patient again and heal the trust that may have been lost.