Anyone who knows me knows that I am a big fan of best-selling author Malcolm Gladwell. In the 10 years since the publication of his groundbreaking book, *The Tipping Point*, I have rarely come upon a popular book that has more relevance to health care. The central thesis of *The Tipping Point* is that ideas, behaviors, messages, and products often are spread – or transmitted - like outbreaks of an infectious disease. When these “social epidemics” reach a critical mass – the so-called tipping point - they engender changes in society’s behavior. Gladwell argues persuasively that a single, imaginative person applying a well-placed lever is capable of moving the world. I couldn’t agree more with his hypothesis after I read through the articles in this issue. These authors are living proof!

This issue of *Prescriptions for Excellence in Health Care* completes the series of articles that feature initiatives addressing 1 or more of the priorities set forth by the National Priorities Partnership (NPP). The lead article, “Patient Safety: A Patient Perspective,” is a testament to the power of a single individual in “improving the safety and reliability of America’s health care system.” After suffering from the effects of a serious medical error, the author formed a national organization that helps patients and the medical professionals who treated them recover from the effects of adverse events. Efforts such as these may go a long way to prevent such occurrences in the future.

In the second article, “Building an Accountable Care Organization in Camden, NJ,” the author takes us on a follow-up visit to an inner-city project that touches upon 3 NPP priorities – namely improving the health of the population, ensuring that all patients receive well-coordinated care within and across all health care settings and levels of care, and eliminating overuse without compromising the delivery of appropriate care. This project demonstrates that amazing results can be achieved in the most unlikely circumstances given the right person at the helm.
The final article, “Convenient Care Clinics: Innovations in Patient-Centered Care,” explores the ways in which these innovative clinics are advancing the NPP goal of ensuring well-coordinated care for patients within and across various health care organizations and settings.

In the midst of the negatively charged turmoil surrounding US health care, it is refreshing to learn of the positive "social epidemic" emerging from initiatives such as those featured in this series. As always, I am interested in your feedback; you can reach me by e-mail at: david.nash@jefferson.edu or visit my blog at: nashhealthpolicy@blogspot.com.

David B. Nash, MD, MBA is Founding Dean and the Dr. Raymond C. and Doris N. Grandon Professor, Jefferson School of Population Health.

References:

A Message from Lilly

Safety Matters
By Donald G. Therasse, MD

In recent years, greater emphasis has been placed on patient safety and pharmacovigilance systems that aim to minimize the risks and maximize the benefits of pharmaceutical products for targeted patient populations. The result has been a revised approach to pharmaceutical risk management and risk communication, which provides an excellent opportunity for more effective interactions and increased transparency with regulators, health care providers (HCPs), and patients.

Increasingly, regulators are communicating potential serious risks to the public earlier in the evaluation process. Although some consumers, patients, and HCPs welcome this information, others find such messages confusing or misunderstand what the communications are intended to convey. These communications often lack broad context regarding benefit and risk, and are delivered in the absence of a clear explanation of how the safety surveillance system works.

The safety of patients using Lilly medicines is our highest priority.

Beginning with the discovery of a potential new drug, and for as long as it is available to patients, our goal at Lilly is to ensure that the benefits and risks of a medication are continuously monitored and well understood by regulators, HCPs, and patients. Even after thorough research in clinical trials, Lilly continues to carefully monitor for new safety information, so safety evaluation does not stop when a medication reaches the market. In fact, the monitoring increases through collection of information from ongoing clinical studies and through reports received directly from the HCPs and patients who use the medicine. Lilly shares new findings and emerging concerns openly with regulators and HCPs to ensure appropriate management of the risks associated with the use of our medicines.

Safety Matters Web Site

Accurate and up-to-date safety information is critical for HCPs and patients to best decide how and for whom a medication should be used. Lilly recently launched a new section called Safety Matters (http://safetymatters.lilly.com/) on its Web site to provide HCPs with additional information on how Lilly monitors the safety of its products. Safety Matters also includes links to the US Food and Drug Administration (FDA) Web site and provides an explanation of the Global Patient Safety (GPS) organization within Lilly.

As part of the development of the Safety Matters Web site, Lilly conducted interviews with HCPs and researched similar Web sites of other pharmaceutical companies. The interviews with HCPs showed that:

• Many are not aware of the FDA site as a resource for product safety information.
• They infrequently report adverse events.
• They are unaware of pharmacovigilance processes.
• They believe that only those adverse events that are unusual, unexpected, or serious are to be reported.

Safety Matters includes sections that highlight the safety-related roles of HCPs, Lilly, patients, and the FDA. It also includes links to prescribing information and medication guides for all Lilly medications, as well as links to a number of relevant FDA Web sites, including specific links and instructions about how to report an adverse event. A separate section explains the company’s
pharmacovigilance processes, which are designed to continuously monitor, evaluate, and communicate a drug’s safety profile. The Safety Matters site currently focuses on a US audience, but plans call for it to be expanded globally.

**Lilly Global Patient Safety**

The GPS organization is a team of over 300 individuals, including physicians, pharmacists, nurses, and other drug safety professionals, who have the core responsibility for pharmacovigilance and the continuous monitoring of the benefit/risk balance of Lilly’s products. GPS continuously and actively monitors safety information from sources around the globe. When a safety finding is identified, the GPS team works with regulatory authorities to inform HCPs and patients. This information is communicated through changes to the medication’s package insert, patient information guide, and occasionally through letters sent directly to HCPs or by other means. When necessary, additional studies are conducted to further assess and understand the safety profile of the medication.

Lilly aims to model good risk communication practices through the Web site, and to create an evidence-based communication tool that could be adopted by others who communicate risk information to the public. It is important for Lilly, regulators, HCPs, and patients to work together to ensure that all stakeholders understand their roles in patient safety and the pharmacovigilance process, and in the reporting of any potential adverse event that occurs during or after treatment with a medication.

**Donald G. Therasse, MD,** is Vice President of Global Patient Safety at Eli Lilly and Company.

---

**Patient Safety: A Patient Perspective**

*By Linda K. Kenney*

As the famed Institute of Medicine (IOM) report, *To Err Is Human*, was being released in November 1999, I underwent total ankle replacement surgery at a major medical facility in Boston, Massachusetts, expecting to wake up the same day with a new ankle. Instead, I awoke several days later to find that the nerve block had accidentally been delivered to my heart. I had gone into cardiac arrest. An emergency sternotomy with cardiopulmonary bypass for cardiac resuscitation had been performed to save my life.

This incident had a profound effect on me, my family, and my friends. However, it also offered me a glimpse of a side of health care that most patients and families never see - the emotional impact this adverse event had on my orthopedic surgeon, the anesthesiologist, the code team, and other health care providers who had witnessed it. It wasn’t just “business as usual” for them. They hurt too, and as unsupported as I and my family did. I knew then that something needed to be done.

With the help of some extraordinary people, I founded Medically Induced Trauma Support Services (MITSS), Inc., in June 2002. Our mission is to support healing and restore hope to patients, families, and clinicians following adverse medical events. Recognizing that *everyone* involved in an adverse event needs support, MITSS strives to:

- Raise awareness.
- Educate consumers, health care professionals, and organizations about the emotional impact of adverse events and the need for support services.
- Provide direct support to patients and families as well as individual clinicians.
- Advocate for health care organizations to build infrastructures that support their staff.
- Serve as consultant and advisor to develop patient, family, and clinician support programs.

**Scope of the Problem**

National patient safety and quality movements in health care recognize the emotional impact that medical errors and unanticipated outcomes have on patients, families, and clinicians. The IOM report, *To Err Is Human*, estimated that 98,000 people die from medical errors each year. The Institute for Healthcare Improvement’s 5 Million Lives Campaign calculated that there are approximately 15 million adverse medical events each year, 6 million of which cause harm to the patient resulting in a significant deviation in the patient care process. In the hospital setting, this conservatively translates to...
12 million affected family members and 12 million health care providers who are emotionally impacted by these events each year (Table 1).\textsuperscript{2} Despite the multitude of patients, families, and health care providers affected, only a small number of systems have been set up to address the emotional impact.

### Patients and Families

Almost all adverse medical outcomes have some psychological consequences for patients and their families. These range from worry and distress to depression and despair. The full impact of some incidents becomes apparent only in the longer term. Surprisingly, little attention has been paid to the long-term consequences for injured patients, and very few health care organizations have taken the full responsibility of looking after the people who have been harmed.\textsuperscript{3}

For patients and families, the impact of a medical injury differs from most other accidents in 2 very important respects:

1. Because unintentional harm has been caused by health care providers in whom patients have placed significant trust, reactions may be especially powerful.

2. In general, patients continue to receive care in the same health care setting, and possibly from the same care providers, that harmed them. As a result, they may experience a range of conflicting feelings.\textsuperscript{4}

Patients are at risk of being injured twice – once from the initial medical care they received and again if the health care provider’s follow-up care is not transparent and compassionate. Following a serious adverse event, patients should receive timely, accurate, and empathetic communication, as well as assurance that a diligent investigation is under way. At minimum, the patients’ emotional and social needs should be addressed by sympathetic caregivers. Care may also include psychological counseling.\textsuperscript{3}

### Patients and families want 4 things from health care providers following an adverse medical event:

1. Transparent communication in real time (ie, they want to know exactly what happened).

2. An apology for or acknowledgement of the adverse event.

3. An organizational response (ie, an explanation of how the provider organization will prevent a recurrence of the event).

4. Appropriate support that takes into account variations among individual patients.\textsuperscript{5} This may include financial, emotional, and/or home health care services.

Health care organizations must begin to provide more training and education to their medical staff regarding the short- and long-term emotional impact of adverse medical events on patients and their families. Further, organizations should develop internal systems to better meet the emotional needs of patients and families following these events. The LEND System (Figure 1), was created by MITSS as a tool to help care providers consider how best to support patients and families.

In recent years, there has been a remarkable shift toward greater transparency, disclosure, and apology. Increasing numbers of health care organizations are opting to “do the right thing” by providing patients and their families with an explanation of what happened, an apology, and a plan to prevent the event from recurring. However, patients and families often report that, even when things are handled with honesty and compassion, the emotional impact still may be devastating. Emotional issues (eg, feelings of anger, guilt, loss, fear of reengaging with the health care system) may not arise until 3 to 6 months after the event, and may linger for a prolonged period of time. Sometimes, these patients and their families require long-term emotional support services.

### Table 1. Patients affected by medical error each year

<table>
<thead>
<tr>
<th>Event</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deaths due to medical error</td>
<td>98,000/year</td>
</tr>
<tr>
<td>Affected family members</td>
<td>&gt;196,000/year</td>
</tr>
<tr>
<td>Affected clinicians</td>
<td>&gt;196,000/year</td>
</tr>
<tr>
<td>Patients surviving significant medical error</td>
<td>&gt;6,000,000/year</td>
</tr>
<tr>
<td>Affected families and clinicians</td>
<td>&gt;24,000,000/year*</td>
</tr>
<tr>
<td>Total affected</td>
<td>&gt;30,000,000/year*</td>
</tr>
</tbody>
</table>

*Assuming: the patient has at least 2 family members and 2 care providers closely involved with his or her care.

---

**Figure 1. LEND System**

**LISTENING** - The goal of listening in this situation is not to placate, but to demonstrate a desire to understand how the patient feels.

**EMPATHIC RESPONSE** - While it is impossible to completely understand what a patient or family is going through, it is important to show a desire to understand and a willingness to be supportive. The focus here is not fixing the problem, but allowing the patient/family the space to express their pain.

**NEEDS ASSESSMENT** - Throughout the conversation, try to identify the person’s needs.

**DIRECTING TO SERVICES** - It is important to follow through with commitments and to direct the patient and/or family member to any and all services that may benefit them. Pastoral Care, the Social Work Department, and MITSS are some of the resources available for follow-up support. It is important that patients/families do NOT leave without knowing about resources they can turn to when the going gets rough.
Clinicians and Staff

In 2000, Albert Wu coined the term “second victim” when referring to the physician, nurse, or other clinician on the “sharp end” of a medical error. Physicians have reported experiencing powerful emotions following an adverse event (i.e., guilt about harming the patient, disappointment about a failure to practice medicine to their own high standards, fear of a possible lawsuit, anxiety about the repercussions the error might have on their reputation). Nurses have described experiencing symptoms similar to post-traumatic stress disorder in addition to sensing a loss of professional respect (for themselves and from colleagues), emotional distress, and feelings of anger, guilt, and inadequacy. The emotional impact of a medical error or unanticipated outcome on a care provider can affect his or her ability to function safely in a clinical environment. Emotional support services can minimize or ameliorate the psychological and physical stress on clinicians and help to facilitate a timely and healthy return to normal activity.

In recent years, more attention has been directed at supporting the “second victim.” A number of programs and models have sprung up across the country. In 2004, Kaiser Permanente rolled out a support model for clinicians through its Employee Assistance Program. Brigham and Women’s Hospital in Boston, MA, has successfully piloted a “peer support program” in its operating room, a program that is being implemented throughout the hospital. At Children’s Hospital Boston an Office of Clinician Support has been established, led by its psychiatrist-in-chief and chairman of psychiatry. Ideally, short- and long-term, formal and informal, internal and external support services should be made available in an all-inclusive clinician support program. Such services will be utilized as options become available and as providers become comfortable with a particular modality. Because there have been many barriers to making these positive changes (Figure 2), a strong preeducation program will be necessary to address and eventually overcome them.

Role of Health Organization Leadership

Given the profound impact of adverse medical events on clinicians, patients, and their families, it is incumbent on health care leadership to provide appropriate support to each. Leaders must establish and nurture a culture of quality and safety that is honest, empathetic, respectful, and forgiving. It is likely that every young person beginning medical education today will be involved in a serious adverse medical event at some time in his or her career. Given this stunning statistic and its implications for the clinicians and patients involved, health care leaders must play an active role in reducing the emotional toll and fostering a climate of compassion and mutual respect. Commitment from the top levels of leadership and allocation of necessary resources are key elements of the successful support models described.

Conclusion

Since MITSS’s inception in 2002, we have witnessed significant progress toward a goal of supporting everyone involved in an adverse medical event. Although some successful clinician support programs have sprung up, support services available to patients and families beyond the hospital stay remain very limited. MITSS is committed to providing greater awareness, educating all involved (and potentially involved) parties, providing direct support services as needed, and advocating for systemic change in health care organizations’ responses to these events.

Linda K. Kenney is Executive Director and President of Medically Induced Trauma Support Services, Inc. She can be reached at: lkkenney@comcast.net.

References


Figure 2. Barriers to Positive Culture Change with Respect to Adverse Medical Errors

- Perception of the clinician as “superhuman”
- Culture of clinical “perfection” instilled by Hippocratic Oath: “First do no harm”
- Feelings of shame, humiliation, and incompetence
- Culture of fear regarding medical-legal action
- Intense emotional discomfort caused by adverse medical events
- Lack of systems thinking
Building an Accountable Care Organization in Camden, NJ

By Jeffrey Brenner, MD

As our nation surpasses $2.5 trillion in health care spending—$1 of every $5 spent—health reform efforts will increasingly focus on reducing costs. Expanding coverage is relatively easy; lowering costs is much harder. Today every stakeholder in the health delivery system is working to maximize revenue by increasing market share and volume. Fifty years of learned behavior will be difficult to change, even if changes are made to the reimbursement system.

Policy makers must begin to lay the groundwork for the new behaviors that must emerge (ie, the ability to collaborate across institutions, coordinate care, improve safety/quality, share data, share resources, expand primary care, conduct regional health planning). Sadly, organizations capable of facilitating these activities do not exist in most regions.

For too long we have depended on entities far removed from the point of care to change provider and hospital behavior. Health insurers have used preferred contracts, referrals/precertification, and remote nurse call centers. In general, these blunt tools for altering behavior have failed to lower health care costs. Providers and hospitals have learned how to subvert these cost control efforts. Moreover, the highest cost patients do not respond to remote nurse call centers with no face-to-face contact.

Ultimately all health care is local. Driving down costs and improving quality will require health care providers to work together with hospitals and social service providers on a collaborative mission that focuses on the needs of their patients and community.

Evidence from the Dartmouth Atlas

The importance of the local health care marketplace has been highlighted by the Dartmouth Atlas, which demonstrates unacceptable regional variations in cost and health care utilization for Medicare patients. The Atlas shows that costs in a state, region, city, or hospital are tied more to health care supply than patient need. Indeed, high-cost regions are characterized by:

- Oversupplies of specialists and hospitals
- Ineffective use of primary care
- Uncoordinated and often unnecessary services of no benefit to the patient.

The behavior, costs, and utilization in a region are tied to the complex relationships and habits that develop between primary care physicians, hospitals, and specialists. Researchers have documented that patients who receive health care in a highly integrated system, such as Kaiser Permanente, receive higher quality care at a lower cost.

Atlas researchers are calling for the creation of an integrated health delivery organization that mimics the behavior of tightly integrated organizations. These Accountable Care Organizations (ACOs) would use payment arrangements as incentives for local providers and hospitals to provide high-quality, efficient, cost-effective, and integrated care. Payment reforms might include gainsharing, bundled payments, no payment for readmissions, pay for performance, expanding primary care through the patient-centered medical home, and global capitations.

Building the Camden Coalition of Healthcare Providers

Local health care providers have been working for 8 years to build the Camden Coalition of Healthcare Providers (CCHP), a nonprofit organization committed to improving the quality, capacity, and accessibility of the health care delivery system in Camden, NJ.

The Coalition built a citywide health database using claims data from 3 local hospitals. The database now contains the name, address, date of birth, date of admission, insurance status, diagnosis codes, charges, and receipts for every Camden City resident who has been to a local hospital or emergency room (ER) from 2002 through 2007. These data revealed that 50% of the city’s residents use an ER or hospital every year—twice the national rate. The vast majority of these visits are for acute and chronic problems that could be prevented with better access to primary care.

From 2002 to 2007, 13% of the patients accounted for 80% of the costs (mostly to Medicaid and Medicare) and 20% of the patients generated 90% of the costs. The most expensive patient had $3.5 million in receipts. The top 1% of patients (1035 residents) visited the ER and hospital between 24 and 324 times.

Targeting Super Utilizers

The database provided critical information that eventually galvanized support from local stakeholders and foundations to target high-cost/high-needs patients. These patients have significant barriers to care including homelessness, substance abuse, severe chronic illnesses, physical disability,
and mental health problems. The chief advantage of a citywide coalition is its ability to encourage collaboration and data sharing among hospitals, to identify common challenges, and to address the challenges with coordinated solutions. Our project tracking data showed an initial decrease in these individuals' utilization parameters and an improvement in their collections rate.

For much of Camden's population, reducing ER and hospital utilization will require transforming local primary care offices into high-performing, modern, patient-centered medical homes, with features such as multidisciplinary care teams, electronic health records, open-access scheduling, and patient registries. In reality, primary care providers and clinics operating in underserved communities struggle to keep their offices open. Unsafe communities, break-ins, low reimbursement rates, complex patients, and difficult insurance requirements create monumental challenges to providing high-quality care. Our Coalition has begun to lay the groundwork for transitioning local practices into National Committee for Quality Assurance-certified medical homes through monthly office manager meetings, provider education programs, individual practice assessments, and technical assistance.

**Camden Diabetes Collaborative**

Recently, the CCHP received a $2 million, 5-year grant from the Merck Foundation to build the Camden Diabetes Collaborative. The goals of this collaborative include:

- To transform 10 local practices into patient-centered medical homes using the Chronic Care Model for patients with diabetes
- To develop accessible, neighborhood-based diabetic education programs with ongoing peer-led self-management programs

Much of this effort is driven by the hospital claims data assembled in the health database. The Coalition has mapped the claims data for diabetic patients at the neighborhood level (Figure 1). The next step will be to match individual primary care billing data with the hospital data, allowing the Coalition to identify the hospital and ER utilization of the patients in each practice, regardless of payer.

In the first year, each practice will be asked to work with the Coalition's high-utilizer team to target 4 of their most expensive diabetic patients. The database will be used to measure outcomes.

**Expanding the Analysis**

Using the citywide claims database, the Coalition has begun to expand its analysis to find key opportunities to reduce costs by reducing ER and hospital utilization across the community (Figures 2 and 3).

**Building an Accountable Care Organization**

As noted previously, ACOs are envisioned as voluntary community-based groups of providers capable of delivering coordinated, high-quality, and cost-effective care. The providers, from various corporations and/or group practices, would receive incentive-based, gainsharing payments in exchange for lowering costs and increasing quality.

(continued on page 8)
Prescriptions for Excellence in Health Care

Figure 2. ER/Hospital Use by Census Block: Claims Data Analysis for One “Hot Spot”

CCHP hospital data show that patients who make excessive use of ER and hospital services move from ER to ER and hospital to hospital. In Camden, an ACO would be an integrated group of providers from all 3 local hospitals that focuses exclusively on the special services needs of the underserved patient population. An ACO is most likely to succeed in a small, poor, underserved community like Camden because the market penetration of Medicaid and Medicare is quite high, reducing the amount of coordination necessary between payers.

The CCHP is beginning to exhibit much of the behavior necessary within an ACO, including the ability to understand and use claims data, the linkages needed to build collaborations between medical and social service providers, the capacity to provide targeted care management to high-cost/high-needs patients, and the relationships with primary care providers to help with their transformation into patient-centered medical homes.

Jeffrey Brenner, MD is a Clinical Instructor in Family Medicine at the Robert Wood Johnson Medical School in Camden, New Jersey. He is the Medical Director and Founder of the Camden Coalition of Healthcare Providers. He can be reached at: jeffrey.brenner@verizon.net.

References:

Convenient Care Clinics: Innovations in Patient-Centered Care

By Sandra Festa Ryan, RN, MSN, CPNP

Convenient care clinics (CCCs) promote patient-centric care by engaging patients and their families in managing their health and making informed decisions about their care. Patient-centric care considers each patient’s situation—cultural, social, family, lifestyle, financial, spiritual, and health-related needs and preferences—to provide the best care for that particular patient. Nondirective, patient-centered care creates patient-provider “teams” and supplies the tools and support systems that facilitate the clinician’s effectiveness and the patient’s success in managing his or her health.

Primary care, still considered “the backbone of the nation’s health care system,” is at grave risk of collapse. As the number of primary care physicians decreases, Americans are more likely to lack even basic health care. Increasingly, CCCs are seen as one solution to this growing problem. A recent survey found that more than 1 in 3 consumers are receptive to the idea of using CCCs, with over 16% having used a retail clinic in a 2-year period and 13% having used a retail clinic in the last 12 months. The number of clinics has grown from fewer than 50 in 2005 to more than 1000 today, a level of acceptance and use demonstrating that CCCs are meeting a real need for affordable, accessible, quality primary care.

CCCs, staffed primarily by nurse practitioners and physician assistants, function as partners with primary care physicians (PCPs) to deliver and assure continuity of care. As members of the Convenient Care Association (CCA), a majority (90%-95%) of convenient care operators are held to a common standard of evidence-based care including 10 quality and safety standards with 3rd-party certification, peer review and collaborative physician review, and measurement of outcomes. The essence of patient-centered care—meeting the needs of the right patient, in the right place, at the right time, with the right care—is the driving force of the convenient care industry.

The Right Patient

CCC patients aged 18 months and older span all sociodemographic groups including age, race, sex, and insurance status. The majority of patients are adults between the ages of 18 and 44, and nearly 70% are covered by insurance. The current scope of CCC services—acute self-limiting conditions, vaccinations, physical examinations, and preventive services—may soon be expanded to include chronic disease management.

CCCs provide an important public health service by offering convenient locations for immunizations and by tracking and trending the spread of illness. For instance, 73.6% of CCC patients aged 65 and older use the clinics for immunizations. In addition, these clinics provide important screening and health risk assessment services to identify risks, educate patients, and make referrals for additional services. Earlier access to health care can reduce severity of illness, curtail the spread of infection, encourage preventive care, and reduce overall health care utilization.

The Right Place and Time

CCCs provide care convenient to where people live and work and at hours that fit into the busy lives of Americans. CCCs typically are open 7 days a week, with hours that extend into the evenings on weekdays. No appointment is needed and wait times are usually short.

The National Association of Community Health Centers found that 56 million US residents do not have a regular source of health care as a result of physician shortages in their area. A recent study found that only 38.7% of CCC patients reported having a PCP. CCCs function as a medical liaison, referring patients without a medical home to a PCP in their community, or to a medical specialist when appropriate and with the patient’s consent. CCCs provide visit summaries that can be shared with patients’ PCPs and offer follow-up visits based on the severity and nature of the illness. An important part of the local health care system, CCCs provide an overflow outlet for busy provider practices (eg, evening, weekend, and holiday coverage) and a cost-saving alternative to overburdened and expensive emergency rooms.

According to the 2005 National Hospital Ambulatory Medical Care Survey, an estimated 55.4% of the annual 114 million emergency department visits are for nonurgent conditions such as headaches, sore throats, and stubbed toes. The cost of the average CCC visit, including medications prescribed, is $51 less than urgent care, $55 less than a doctor’s office, and $279 less than an emergency department setting. The savings from using CCCs instead of emergency rooms are immense.

The Right Care

CCCs provide the right care through the use of evidence-based clinical guidelines that align with those of the American Medical Association (AMA) and the American Academy of Family Physicians (AAFP). The quality of care has been found to be as good as or better than care provided by PCPs and urgent care providers. Nurse practitioners provide higher rates of

(continued on page 10)
counseling and self-management than PCPs, and such counseling can lead to improved health, self-care, and quality of life. Patient surveys demonstrate an 89% quality of care satisfaction rating.

CCCs support their clinicians through the use of health information technology (HIT), which has been shown to improve quality by increasing adherence to guidelines, enhancing disease surveillance, and decreasing medication errors. In addition, the use of a computer-based system increases consumer acceptance of and comfort with care provided by mid-level clinicians.

HIT is used throughout the patient’s visit, from check-in through discharge, including the use of electronic medical records (EMR) by the clinician, e-prescribing, electronic ordering of laboratory tests, medical record transfers to PCPs, and patient follow-up. The EMR permits documentation of the chief complaint, medical and family history, medications and allergies, review of symptoms, physical exam, tests and procedures performed, discharge instructions, and follow-up telephone calls and visits. The EMR also provides CCC clinicians with reminders about patients who need follow-up, automatic checks for pregnancy, and medication allergies and history.

HIT is also useful for collecting data regarding patient satisfaction, Healthcare Effectiveness Data and Information Set (HEDIS) measures, real-time peer and collaborating physician review, and for tracking provider compliance with mandatory continuing education—an important component of ensuring continuous quality improvement. It creates a constant awareness of quality standards and the need to follow evidence-based guidelines.

Currently 6 in 10 Americans defer health care because of cost, while the country struggles with rapid increases in health care costs, an aging population, unprecedented Medicare and Medicaid spending, and rising numbers of uninsured. CCCs offer an innovative solution by meeting individuals’ basic health care needs conveniently, at a reasonable cost, and in a fashion that can be scaled to meet the needs of the country as well.

Sandra Festa Ryan, RN, MSN, CPNP, is Chief Nurse Practitioner Officer for Take Care Health Systems and Cochair of the Clinical Advisory Board, Convenient Care Association. She can be reached at: Sandra.Ryan@takecarehealth.com.

References

Key Healthcare Quality Organization Websites

Agency for Healthcare Research and Quality (AHRQ)
Federal agency charged with improving quality, safety, efficiency, and effectiveness of health care.
www.ahrq.gov/qual/

AQA Alliance
Focuses on improving patient safety, healthcare quality, and value by means of measuring performance at the physician/clinical group level and reporting outcomes with meaningful information for decision makers.
www.aqaalliance.org/

Institute for Healthcare Improvement (IHI)
Global resources for improving the quality of health care
www.ihi.org/IHI/about

National Quality Forum
Promotes change through development and implementation of national strategies for health care quality measurement and reporting
www.qualityforum.org/

Healthcare Quality Organization Meetings of Interest:

Annual Quality Colloquium at Harvard
A hybrid conference, Internet event, and training tool
August 16–19, 2010
http://www.qualitycolloquium.com/

Joint Commission Annual Conference on Quality and Safety
http://www.jcinc.com/callforpresentations2010/annualconference/

American Medical Group Association
Institute for Quality Leadership Annual Meeting: Creating High–Performance Care Organizations
Hollywood, FL – September 29–October 1, 2010
http://www.amga.org/Education/IQL/index_iql.asp

Institute for Healthcare Improvement (IHI)
22nd Annual National Forum on Quality Improvement in Health Care
Orlando, FL – December 5–8, 2010
http://www.ihi.org/IHI/ProgramsConferencesAndSeminars/22ndAnnualNationalForumonQualityImprovementinHealthCare.htm.player=wmp