

Thinking Out Loud... A Handful of Wind - A Pearl of Care

“And thus, like the wounded oyster, he mends his shell with pearl.”

—Ralph Waldo Emerson¹

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Today, just before starting this installment of Thinking Out Loud, we took our three-year-old granddaughter on a cool September morning walk in her vivid red jogging stroller. A breeze blew in gentle gusts and swirled her hair round her head like a halo, though the stroller's two sides stood on each side of her like granite walls protecting a cove. As we walked ahead, she leaned forward and stretched out her hand. With a slight laugh in her voice she firmly told us that she wanted to catch the wind in her hand so that she could give it to her mommy as a gift. At this moment, she seemed the epitome of humanity's best intentions—recognizing the ideal, attempting to make it real.

Experiences such as this one reconstitute the best side of our nature so that, by seeing the world anew, we are better able to negotiate the world at large. So it is with those who care for the infirm and who wish to give their charges the gift of their high-quality care.

Quality Improvement: Large and Small Healthcare Systems

Sheldon Greenfield, MD, and Sherrie Kaplan, PhD, MPH, are two

such individuals who, by promoting the concept of “from bench to bed” hope to improve the quality of patient care. Together they have authored the editorial, “Creating a Culture of Quality: The Remarkable Transformation of the Department of Veterans Affairs Health Care System,”² written to introduce the study, “Diabetes Care Quality in the Veterans Affairs Health Care System and Commercial Managed Care: The TRIAD Study.” The authors carefully explain that the conclusions of the study are valid because its methodology is able to parse the data related to the clinician as well as the data related to the locus of care. Each set of data retains its distinctness, one from the other. If the study had “confounded” the one with the other, the hierarchical modeling method it used to derive the study's results would have been inaccurate. Greenfield and Kaplan, therefore, conclude that one of the study's conclusions—care provided at a single VA site is relatively homogeneous among its clinicians—is a valid conclusion.

They cite another factor that contributes to the study's validity—namely, its utilization of *consistent standards* to measure and evaluate

the results across the entire VA healthcare delivery system. By so doing, the results gain the advantage of equivalency, comparability, and usability... important foundations of a quality improvement program, foundations that an electronic medical record system can then use to inject standard procedures into the process of care.

Having been both a patient and a former caregiver (of my mother before her death in 2001), my interest in the authors' statement at the end of their editorial is especially keen: “Extending these ‘mega-system’ quality improvement programs into the microenvironments of solo and small group practices, where most chronic disease care in the United States occurs, is a more serious challenge.”²

The real challenge is minimizing variation in care by converting the *difficult to do into the easy to do* with the aid of information technology. Chronic care is, by its nature, as continuous as it is sporadic, generally unraveling over time along a defined path, eventually erupting into acute care. To those who oversee it, its evolution may, at times, seem uneventful, whereas those who come upon the scene as

temporary advisors may see it otherwise. It is akin to the well-known observation that a frog, when placed in a pot of cool water, will not jump out of the pot if the water is brought gradually to a boil. The frog will patiently stay in the pot and boil with it. It is only when the frog is placed precipitously into a pot of boiling water that it will jump out.

Such is the patience and obedient observance that are needed to optimally treat a chronic care patient, and this is the role that a clinical information system serves as it helps those in the care trenches know the right things to do at the right time. We can begin to overcome the challenge of achieving consistently high quality in healthcare delivery by inserting *investment-grade* information technology into the process of care.

Prevention: The Unit of Care

A significant complement to this study is a recent, large, 52-country study, conducted by Salim Yusuf of McMaster University, Hamilton, Ontario, Canada. This study begs the same question as the study above, but from a different perspective. Its perspective capitalizes on the notion that circumscribed prevention and intervention can improve the quality of care. This is the figurative low-hanging fruit inherent to the ISO-9000 and Six Sigma quality measurement and improvement methodologies. The study compares 15,152 first-time heart attack patients with 14,820 people who had not experienced a heart attack. They were of the same gender, from the same respective regions, and of a similar age. The study isolates nine easy-to-identify risk factors associated with 90% of all heart attacks that are common to “essentially every region and ethnic group around the globe.”³ Two of the risk factors identified in this study also contribute to chronic kid-

ney disease—namely, high blood pressure and diabetes.

The thrust of the study is prevention, advising that we all make lifestyle choices and do the right things in order to minimize the risk of having a heart attack (daily consumption of fruits and vegetables, routine exercise, and moderate alcohol consumption). Pivotal to this kind of intervention is tracking what a patient needs, identifying risk factors that evolve over time, and intervening with appropriate care in advance of an adverse clinical event. This is routine work for a clinical information system such as Health Informatics’ TIME® System.



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Re-engineering Care

The good news is that information technology is increasingly seen as a mandatory component of healthcare delivery, a fundamental genetic re-engineering of our medical system. Karen Haase-Herrick, president of the American Organization of Nurse Executives, predicts that technology will change the relationship between the patient and nurse. She believes that the nurse of the future will have to know not only how to access knowl-

edge in order to care for a patient, but, once accessed, how to synthesize it in order to provide quality patient care. Believing that technology will ultimately inject nursing presence into the miles that separate patient and nurse, future nursing care will become a blend of hands-on and virtual care, a rewiring of current practice that goes to the core of our humanity.⁵ The practice of medicine is becoming the practice of information!

A Conclusion of Hope

We live in a chaotic and turbulent world... a wounded oyster. In its midst are those good people who would serve others by helping to *heal* them. As they mend others, they move the less noble events we see in the news to the side and make room in our minds for their pearls of care. It is my belief that “we all need to be understood through our highest level of functioning”⁴ and through the ideals that underwrite them.

With this in mind, my hope is that the nephrologists and renal nurses, the clinical researchers and renal dietitians, the social workers, renal technicians, and administrators who participate in events such as the American Society of Nephrology’s Renal Week will continue to search for answers and make real the ideals they espouse on behalf of the patients whom they serve.

References

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