Integrating Clinical Decision Support at the Point of Care: A Look into the Future

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CPM Resource Center, an Elsevier business
Objectives

- Describe latest incentive guidelines/programs related to EHR adoption (ARRA MU, ACOs, etc)
- Identify how clinical decision support (CDS) can be effectively integrated into the clinical workflow
- Describe how a culture and professional practice framework supports sustainable change
Opportunities Create “Meaningful Care”

ARRA/ Meaningful Use  
Accountable Care Organizations  
Center for Medicare and Medicaid Innovation  
Culture and Professional Practice Framework for Sustainable Healthcare
The Future of Healthcare
“I can see so far because I have stood on the shoulders of giants”

~Isaac Newton
MIND SET!
Reset Your Thinking and See the Future

John Naisbitt (2006)
How are you addressing MU and ACOs today?

ARRA/PPACA

Shared Work Team

CPM Partnership Council

Elsevier HIT Policy Group (Reed Elsevier GA & HL)

One-On-One

CPM Advisory Board

Meaningful Use and Accountable Care Collaborative Learning Community (CLC) May 2011
The Evolution of Meaningful Use

2009

HIT-Enabled Health Reform

2011

Stage One Meaningful Use Criteria (Capture/share data)

2013

Stage Two Meaningful Use Criteria (Advanced care processes with decision support)

2015

Stage Three Meaningful Use Criteria (Improved Outcomes)

Meaningful Use Criteria

HITECH Policies

Source: ONC HIT Policy Committee
We believe greater clarification is required around the term clinical decision support. We propose to describe clinical decision support as health information technology functionality that builds upon the foundation of an EHR to provide persons involved in care processes with general and person-specific information, intelligently filtered and organized, at appropriate times, to enhance health and health care.
Notice of Proposed Rule Making on the Medicare and Medicaid; Electronic Health Record Incentive Program

- **Recommendation 1:** The description for clinical decision support should be expanded to include clinical information and should not solely be defined by technology functionality. *(Accepted)*

- **Recommendation 2:** The role of nurses and allied health professionals should be explicit in the meaningful use health outcomes policy priorities, care goals, and 2013 objectives.

- **Recommendation 3:** Evidence-based care plans should be added to the 2013 meaningful use objectives and measures in order to capture the professional processes of care by the entire interdisciplinary care team.

- **Recommendation 4:** A distinction should be made by CMS between the use of EHR data for submission of quality reports and the use of the actual EHR system for purposes of submission, making clear that stand-alone analytics and reporting tools may be used for submission as well. *(Accepted)*
Meaningful Use Stage 2
CPM Recommendations

• Patient Centered Care Delivered by Interdisciplinary Teams

• Clinical Decision Support (CDS) Integration and Certification

• Interdisciplinary Integrated Clinical Documentation

• Longitudinal Care Plan
EHR Incentive Programs

Overview

The Official Web Site for the Medicare and Medicaid EHR Incentive Programs

This official web site provides up-to-date, detailed information about the Electronic Health Record (EHR) incentive programs. Use the tabs to the left to find additional information regarding various aspects of the program.

Background

The nation's healthcare system is undergoing a transformation in an effort to improve quality, safety and efficiency of care, from the upgrade to ICD-10 for information exchanges of EHR technology. To help facilitate this vision, the Health Information Technology for Economic and Clinical Health Act, or the "HITECH Act" established programs under Medicare and Medicaid to provide incentive payments for the "meaningful use" of certified EHR technology. The Medicare and Medicaid EHR incentive programs will provide incentive payments to eligible professionals and eligible hospitals as they adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology. The programs began in 2011. These incentive programs are designed to support providers in this period of Health IT transition and instill the use of EHRs in meaningful ways to help our nation to improve the quality, safety and efficiency of patient health care.

NOTE: This is a new program, and it is separate from other active CMS incentive programs, such as Physician Quality Reporting Initiative (PQRI), Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) and e-Prescribing.

Establishing the New Program

CMS is establishing the EHR incentive program through formal rule making. A proposed rule on the EHR incentive programs (and the definition of meaningful use) was published, and CMS accepted public comments for 60 days, which ended on March 15, 2010. More than 2,000 comments were received. CMS is currently working to develop and release the final rule in late spring/early summer 2010. This rule will provide many of the parameters and requirements for the Medicare & Medicaid EHR Incentive Programs. A copy of the proposed rule and related documents is accessible below in the Downloads and Links inside CMS sections.

CMS' Role in Other HITECH Areas

CMS is also working with the Office of the National Coordinator for Health Information Technology (ONC) in developing standards, implementation specifications, and certification criteria for EHR technology. More information on certification can be found in the tab on the left.

Patient privacy and security is an important consideration in implementing the EHR incentive programs. CMS is also working with the Office for Civil Rights (OCR) and ONC to address the privacy and security protections under HITECH Act. More information on privacy and security related to the Health IT is available by clicking "Health IT/Privacy and Security" and "CMS Office for Civil Rights" in the Related Links Outside CMS sections below.

Downloads

Fact Sheet: Medicare and Medicaid EHR Incentive Programs: Title IV of Recovery Act

Press Release: CMS and OCR Issue Regulations Proposing a Definition of "Meaningful Use" and Setting Standards for EHR Incentive Program

Copy of Published Proposed Rule for EHR Incentive Programs and Definition of Meaningful Use [77.37 KB]

Fact Sheet: Proposed Requirements for Medicare EHR Incentive Program

Fact Sheet: Proposed Requirements for Medicaid EHR Incentive Program

Fact Sheet: Proposed Definition of Meaningful Use

Related Links Inside CMS

Health IT Frequently Asked Questions

Related Links Outside CMS

HCFA/Office of National Coordinator Health IT Web Site

Health IT/Privacy and Security

HCFA Office for Civil Rights

Page Last Modified: 06/18/2010 12:00:00 PM

Help with File Formats and FAQs

Submit Feedback

Department of Health & Human Services | Medicare.gov | USA.gov

Web Policies, Notices, and Informational Footer
Accountable Care Organizations

- Clinical Integration
- Medical Homes
- Bundled Payments
- Population Decision Making

Continuum of Care
ACO Proposed Rules

Background & Provisions

- Evidence-Based
- Patient Engagement
- Care Coordination
- Assessments
- Individualized Plan of Care
- Care Transitions
- Quality Performance Standards
- Data Sharing
- Performance Scoring
Accountable Care Landscape

Competencies of ACO
Capable IT Infrastructure

- Care Coordination
- Clinical Knowledge Management
- Patient Engagement
- Operational Risk Management
- Population Risk Management

Practice Tools & Infrastructures

- Order sets, interdisciplinary care plans & integrated clinical documentation
- Evidence-based clinical content resources & tools
  - Updated on continuous basis
- Patient preferences and individualization (mutuality)
  - Analytics solutions to improve team – patient engagement
- Payer & provider risk analytics solutions to improve population health and predictive analytics to support proactive care management
MINDSET #1

While many things change, most things remain constant.

“The more we are able to differentiate between constants and change, the more effectively we will be able to react to the new market and profit from change.”
**Project Driven Change**

Sustainable Quality Outcomes

- Change is put in context of the whole of the organization
- Change efforts leading to positive, sustainable outcomes that support organizations vision

**Framework Driven Change**

- Clear change process to identify & implement initiatives necessary to improve
- Prompt change actions taken to implement projects or initiatives to meet goals

Early Warnings

- Lack of formal processes or methods to carry out initiatives/projects
- Inability to act quickly with initiatives/projects necessary to improve quality outcomes
- Change process started before understanding how it impacts all parts of the organization
- Losing the positive results of change effort because new problems pop up

Unsustainable Quality Outcomes

- Deep fear from lack of balance

**Action Steps**

Establish understanding how a framework guides and sustains transformation

Clearly align framework with initiatives so all see the whole of transformation efforts for sustainable change

Establish guidelines to identify and act on important issues

Synchronize all initiatives with quality improvement efforts and framework integration

Early Warnings

- "We have so many issues we could improve upon if we could focus on them"
- "Nothing gets done quickly around here"
- "Here we go again with another initiative"
- "Don't worry, this will go away just like all the other initiatives in the past"
Framework for IT Management

In the next few years, the transition from fee for service to accountable care organizations/global payments is going to require significant IT change at a time when budgets will become increasingly constrained. We'll have the combination of Meaningful Use Stages 1/2/3, ICD10/5010, and healthcare reform all occurring at the same time.

http://geekdoctor.blogspot.com
The Journey of the Evolving CPM Framework™ and Six Clinical Practice Models
October 06, 2010

Guest Blogger: Laurie Levknecht

The CPM Framework™: Culture and Professional Practice for Sustainable Healthcare Transformation

Hi, and welcome to my blog post. This is an exciting and important time at the CPM Resource Center as we evolve the CPM Framework™ and the Clinical Practice Models in an era of major national changes and the need for a scalable framework to guide healthcare transformation.

http://www.cpmrc.com/resources/blog/
CPM Framework™ and Models

- **Meaningful Care**
  - Supports the patient and clinicians
  - Capture Data → Advanced Processes → Improved Outcomes
  - Aligned with quality standards

- **Accountable Care**
  - Longitudinal Care Planning process
  - Care Coordination across the continuum
  - Intentionally designed documentation tools

- **Transformational Care**
  - Replicable implementation methodology
  - Service strategies for practice and technology advancement
  - Capacity building

Sustainable Transformation
### GPS Global Positioning System

<table>
<thead>
<tr>
<th>Details</th>
<th>Description</th>
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<tbody>
<tr>
<td>U.S. space-based radio navigation system that provides reliable positioning, navigation, and timing services to civilian users on a continuous worldwide basis</td>
<td>A culture and professional practice framework for sustainable healthcare transformation</td>
</tr>
<tr>
<td>Made up of 3 parts:</td>
<td>Made up of 6 models:</td>
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<tr>
<td>Satellites orbiting the Earth</td>
<td>Health and Healing Care</td>
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<td>Control and monitoring stations on Earth</td>
<td>Interdisciplinary Integration</td>
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<td>GPS receivers owned by users</td>
<td>Applied Evidence-Based Practice</td>
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<td>Health Informatics</td>
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<td>Partnership Culture</td>
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<td>International Consortium</td>
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<td>Users can accurately locate where they are and easily navigate to where they want to go</td>
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MINDSET #2

The future is embedded in the present

• Six year pilot (80’s/90’s)
  • Revealed the Future

  “The first accountability of a leader is to know reality”
  ~Max DePree

• 300 Consortium Sites (2000’s)
  • On-going reality of the Future
Realities Of Healthcare Complexity

Care Coordination Issues
- Lack of Practice Interoperability
- Lack of Content Interoperability
- Lack of interdisciplinary integration vision

System Inefficiencies
- Discipline Silos
- Duplication, Repetition
- Shortages
- Fast-paced environments

Patient Safety Issues
- Lack of evidence-based tools
- Communication issues
- Relationship challenges
- Complex patients
- Increasing regulations

Transitions of Care
- Patient Story not shared

Follow-up

Acute Care

Rehabilitation

Home Care

Emergency

Ambulatory

Surgery
A New Mindset

“The future is embedded in the present”

~John Naisbitt

Newspapers → Social Media
Focus on the score of the game

Transparency & Outcomes
Focusing on Outcomes

• 100% Joint Commission Compliance
• Outperforms U.S. and mean regional CMS Core measure on average 90% of the time
• Increased Nursing Satisfaction
• Decreased Patient Falls
• Decreased Pressure Ulcers
• Tobacco Cessation Teaching Compliance
• Decreased Ventilator Associated Pneumonia (VAP)
• Rapid HIT implementation with Standardization of Care
• Magnet Alignment and Recognition/Recertification
Significant cost savings as a result of preventing Pressure Ulcers (PU), Deep Vein Thrombosis (DVT), Ventilator Associated Pneumonia (VAP), and more that has embedded evidence-based content and clinical decision support with a common practice framework can be profound.
MINDSET #4

Understanding how powerful it is not to have to be right

Core Competencies

Partnerships
Usability and Clinical Application Design

Adapted from the CPM Resource Center with Permission
MINDSET #5

See the future as a picture puzzle

- High Tech/High Touch
- Culture/Technology
- Technology/Practice
CPM Framework™
Partnership Culture Model
Is not simply a “project” or taking paper forms and recreating computer screens
CPM Framework™
Health Informatics Model

Data
Discrete objective

Information
Organize interpret

Knowledge
Synthesize Identify relationships

Wisdom
Use knowledge to manage and solve issues

Professional Processes of Care
Evidence-Based Clinical Decision Support
Integrated Clinical Documentation

Stage 2
Meaningful Use Criteria
Advanced Care Processes with Decision Support

Stage 3
Meaningful Use Criteria
Improved Outcomes
CPM Framework™ Applied Evidence-based Practice Model

CLINICAL DECISION SUPPORT
- Clinical Practice Guidelines
- Evidence-based screens, scales and content

CLINICAL DECISION MAKING
- Inquiry
- Reasoning
- Judgment

EVIDENCE-BASED PRACTICE
- Best evidence
- Clinical expertise
- Patient values

CLINICAL SCHOLARSHIP
- Contribute to bodies of knowledge
- Practice advancement
Interoperability Definitions

- **Intentionally designed automation (IDA)™** expedites interoperable systems by preparing and engaging clinicians, supporting evidence-based practice and delivering quality and safety outcomes.

- **Practice interoperability** is supported by utilizing a professional practice framework to exchange patient information and interdisciplinary professional services across all clinical settings.

- **Content interoperability** is the use of consistent professional data within a practice framework that is exchanged accurately and effectively within the technological systems across the continuum of care.

- **Practice standards** must integrate with **HIT standards** needed to secure exchange of patient and clinician information.

Source: CPM HIMSS Interoperability Showcase Whitepapers (2010 & 2011)
Best Approach to Standardization and Improved Outcomes

Practice-Based
- Professional Practice
- Interdisciplinary
- Evidence-Based Practice
- Scope of Practice
- Clinical Practice Guidelines
- Clinical Documentation
- Critical Thinking/Clinical Reasoning

Standards-Based
- Taxonomies
- Unidisciplinary
- Taxonomic Structure
- Coded Data Sets
- Minimal Data Sets
- Nursing Diagnosis/Language
- e-Quality Measures

And/Both
Standardized Data Elements based on Evidence

- Over 50 Evidence-based Scales/Risk Screens
- Diverse patient populations
- Over 200 Evidence-Based Clinical Practice Guidelines
- Coordinated via a Professional Practice Framework
- Collective contributions and sharing across multiple sites
- Rapid adoption of standardized quality/evidence-based care
The Quality Data Set (QDS)

Source: The National Quality Forum (NQF)
Quality Data Model

Source: The National Quality Forum (NQF)

www.qualityforum.org
Closing the Quality Loop: Meaningful & Accountable Care

- Implement Patient-centric Decision Support
- Measure Outcomes
- Implement Interdisciplinary Order Sets & Clinical Documentation
Interoperability Scenarios

Care Theme: Clinical Decision Support

Act 24 - Care of the Stroke Patient in the Acute Care Setting

Scenario Primary Goal: To demonstrate practice interoperability and content interoperability using a common professional practice framework and clinical documentation model.

New Directions: Interoperability will be expanded to include other considerations for quality, standardized care that supports patients' values and preferences. This scenario demonstrates the following key elements needed to support and sustain comprehensive interoperability including:

- Intentionally designed automation (IDA) expedites interoperable systems by preparing and engaging clinicians, supporting an evidence-based practice framework and delivering quality outcomes.
- Practice interoperability supports utilizing a professional practice framework to exchange patient information and interdisciplinary professional services across all clinical settings.
- Content interoperability involves the use of consistent professional data that is exchanged accurately and effectively within the technological systems across the continuum of care.
Goal/Outcome Evaluation:
01/10/10 2300 Nursing 1/11/10 OT 1400 10/11/09 1900 PT

Stroke (Ischemic)/Transient Ischemic Attack (TIA): Signs and Symptoms of Potential Problems Assessed:
- all

Stroke (Ischemic)/Transient Ischemic Attack (TIA): Signs and Symptoms of Potential Problems Present
- dysrhythmia/arrhythmia,
- motor/sensory skills impairment

Progress:
- improving

Outcome Summary
Continues with moderate right sided weakness. Able to transfer with 2 assist to commode. Atrial fibrillation continues at a controlled rate of 100. Patient verbalizes feeling anxious about his recovery and the rehab process.

Stroke (Ischemic)/Transient Ischemic Attack (TIA): Signs and Symptoms of Potential Problems Assessed:
- abnormal muscle tone, acute neurologic deterioration
- acute pain, cognitive impairment/mood disturbance
- communication impairment, motor/sensory skills impairment, shoulder pain/subluxation,
- situational response, skin breakdown

Stroke (Ischemic)/Transient Ischemic Attack (TIA): Signs and Symptoms of Potential Problems Present
- abnormal muscle tone, acute pain, motor/sensory skills impairment, shoulder pain/subluxation

Functional Deficit: Signs and Symptoms of Potential Problems Assessed: all

Functional Deficit: Signs and Symptoms of Potential Problems Present:
- acute pain, balance impairment, coordination impairment, mobility impairment, muscle strength impairment, muscle tone impairment, sensation impairment

Fall/Trauma/Injury Risk:
achieves outcome

Progress:
- improving

Rehab Services: Progress
- progress towards functional goals is fair

Outcome Summary
Balance on tub bench was only fair, needs constant supervision to prevent falling while using adaptive equipment to bath.

Stroke (Ischemic)/Transient Ischemic Attack (TIA): Signs and Symptoms of Potential Problems Assessed:
- abnormal muscle tone, acute neurologic deterioration
- acute pain, cognitive impairment/mood disturbance
- communication impairment, embolism leading to tissue ischemia/infarction/motor/sensory skills impairment, shoulder pain/subluxation,
- situational response, skin breakdown

Stroke (Ischemic)/Transient Ischemic Attack (TIA): Signs and Symptoms of Potential Problems Present
- abnormal muscle tone, acute pain, motor/sensory skills impairment, shoulder pain/subluxation

Functional Deficit: Signs and Symptoms of Potential Problems Assessed: all

Functional Deficit: Signs and Symptoms of Potential Problems Present:
- acute pain, balance impairment, coordination impairment, functional activity tolerance impairment, mobility impairment, muscle strength impairment, muscle tone impairment

Fall/Trauma/Injury Risk:
achieves outcome

Progress:
- improving

Rehab Services: Progress
- progress towards functional goals is fair

Outcome Summary
Impaired balance and decreased muscle tone in left RLE is significantly impacting safety during bed mobility, transfers and gait skills. Patient has a tendency to become impulsive when frustrated. Proprioception is poor at this time related to upright postures. Requires assist of 2 for all transfer/gait activities due to balance impairment.
Don’t get so far ahead of the parade that people don’t know you’re in it

Transformation Science
Re-thinking Clinical Decision Support and Transformational Implementation

V. Post Activation Audits & On-going Support
- Quality improvement audits
- Updatable
- Research

IV. Practice/Technology Activation
- Interdisciplinary
- Professional Process
- Evidence-based tools
- Integrated/interoperable infrastructure

III. Preparing the Practice Field
- Partnership councils
- Scope of practice education
- Content education
- Content validation

II. Large Scale Engagement
- Implementation planning
- Organizational assessment
- Healthy workplace overview
- Professional practice readiness

I. Strategic Planning
- Leadership education
- Technology validation
- Executive strategic positioning

I. Current documentation (e.g. vital signs, flowsheets)

II. New documentation tools

III. Standardization tools across case settings

IV. Evidence-based reference material

V. IT Training

Outcome Maximization

Generic Build

CPMRC Intentionally Designed Automation™
MINDSET #7

Resistance to change falls if benefits are real

Outcomes
Not Reinventing the Wheel
Our Place in the World: Laying the Foundation for Implementation Science

Learning & Outcomes

CPM RESOURCE CENTER
INTERNATIONAL CONSORTIUM SUMMIT
PROCEEDINGS

NOVEMBER 2009

Our Place in the World: Laying the Foundation for Implementation Science

CPMRC Exemplars

North Shore Long Island Jewish Health System
Cathy Galla, MSN, RN – North Shore Long Island Jewish Health System

Introduction
North Shore Long Island Jewish Health System (NSLIJHS) is the third largest not-for-profit health system in the USA.
- Service area of 6.7 million people—Long Island, Queens, and Staten Island
- More than 38,000 employees being the largest employer on Long Island and the 7th largest in New York City
- We have over 7,000 physicians and over 10,000 RNs.

CPMRC Practice-Technology Transformation
Strategy:
Our leadership strategy took an enterprise-wide approach in the health system. There were several planning calls and meetings with CPMRC and it was determined early that one tertiary campus and one specialty children’s hospital would go first from start to finish in the CPMRC practice-technology transformation. We have assimilated very good strategic planning and partnership with CPMRC and our leadership stakeholders.

Engagement:
We completed an enterprise-wide CPMRC Professional Practice Framework Readiness Assessment and shortly afterwards began the selection and training of CPM Site Coordinators. I became the CPMRC enterprise liaison for Project Care Services. The next step was an enterprise-wide Healthy Workplace Overview in that we had Bonnie Wasonick and Michelle Trosholt provide for hundreds of our interdisciplinary clinical leaders across our enterprise. These sessions were kicked off by our clinical executives to set the context of how this transformational work was the foundation for our Collaborative Care Model and how the EMR implementation was more about transforming care than implementing technology.

Preparation and Activation:
Long Island Jewish Medical Center, which is one of our core tertiary specialty medical centers, as well as, Schneider’s Children’s Hospital were selected to go-live first.

We fully engaged our system-wide work force in creating guiding principles and the voice of end-users was actively sought during the Preparation phase. We committed to a patient-centric, health-system-wide view. Clinicians would be extensively involved in design, configuration, and implementation of the system. We decided to adopt what we called the 60/20 rule as we engaged in the Analysis and Adoption.
MINDSET #8

Things that we expect to happen always happen more slowly

HIT Adoption
Exponential Growth
Example of CPM Framework intentionally designed into *any* HIT System

**Patient Profile:**

**Plan of Care:**

**Education/Outcomes:**

**Assessment/Interventions/Evaluation:**
You don’t get results by solving problems but by exploiting opportunities

Thinking ahead
Leveraging opportunities
Preparing the Workforce for the 21st Century

Evidence & Informatics Influenced by IOM/TIGER: CPM Clinical Practice Guidelines and Documentation is introduced in Health Professions Education
4 Key Messages

• Nurses should practice to the full extent of their education and training

• Nurses should achieve higher levels of training through and improved education system that promotes seamless progression

• Nurses should be full partners with physicians and all health professionals in redesigning healthcare

• Effective workforce planning and policy-making require better data collection and improved information infrastructure.
MINDSET #10

Don’t add unless you subtract

Interprofessional Education and Interdisciplinary Practice
CPM Framework™
Interdisciplinary Integration Model
“Team approaches to care are fundamental to our future in healthcare”

Mary Wakefield, PhD, RN
Administrator
Health Resources and Services Administration
U.S. Department of Health and Human Services

National Academy of Practice
March 26, 2011
MINDSET #11

Don’t forget the ecology of technology

Practice/Technology
Key Questions to Ask
Transitions of Care

Professional Exchange for Transitions of Care
Clinical Summaries that are “Meaningful”

Significant Events:
10/20 - 37 yr old female admitted from ED. Entire family in roll-over MVA. Pinned in car and had to be extricated. Husband (Terry) was thrown from care – SBI is unconscious and in drug induced coma in room 4004. Two children (Trevor 8 and Tory 3) not injured – with patient’s mother. Family is from Gaylord – on way to airport and airlifted here. Family arriving – mother here.
Dx: Incomplete T-6 SCI – no sensation/movement in lower extremities. Fractured ribs on Rt. – pneumothorax – CT inserted to 20 CM suction with sanguinous output. Difficulty breathing and poor ABGs/sats – intubated and vented in ED. Multiple bruises and abrasions – confused at times to what is happening – mixed with restlessness.
10/22: ABGs stable per weaning protocol. Extubated at 3:20pm
10/23: CT dc’d – minimal drainage – tolerated well
10/24: Spinal Fusion done per Dr Wong – stable post-op
10/26: Transferred to 6027 – stable with thoracic lumbar brace on. Pain in upper back torso and neuropathic pain in torso and legs.
10/26: Increasing stretching exercises for Vicky’s legs (per PT)
10/27 – Vicky very emotional – upset about many things. Worried about husband – wants to know what is going on and that everyone knows him. Worried about children – Child Life consulted.

Goal/Outcome Evaluation:
10-27-08 1600
Spinal Cord Injury Signs/Symptoms of Potential Problems Present:
acute pain
Grieving, Actual/Anticipatory:
making progress toward outcome
Outcome Summary:
Experiencing upper back spasms today. Relief achieved with repositioning and medication. Vicky verbalizes that she is experiencing many losses, but right now wants to be strong for her family and Terry.

Plan of Care:
10/27:
Spinal Cord Injury (Clinical Practice Guideline)
Spinal Cord Injury (Individualization)
1. Tap into Vicky’s active strengths! Encourage her ideas for mobility activities and strengthening.
2. Please wake Vicky if resting when Dr White makes rounds – she does not want to miss talking with him.
3. Allow 30 min. rest after PT Sessions (MW – PT)

Grieving, Actual/Anticipatory (Clinical Practice Guideline):
Related/Risk Factors of loss of independence, change in lifestyle, plans and goals
AEB Signs & Symptoms of sadness, anger and grieving (Individualization):
1. Update on husband’s status as frequently as possible
2. Keep journal/equipment at bedside at all times – (KR – MSW)
3. Daily calls from mother EVERYDAY at 5PM – talk with children except Tues and Thurs.
4. Child Life Therapy meeting every Tues and Thursday on unit at 5pm to meet with Vicky’s children – also working with the Vicky and children together (EL - CLT)

Sensory outcome evaluation:
10-27-08 2300
Spinal Cord Injury Signs/Symptoms of Potential Problems Present:
none
Grieving, Actual/Anticipatory:
making progress toward outcome
Outcome Summary:
Vicky has been comfortable and able to participate in physical therapy. She continues to be concerned about Terry and looking forward to seeing him tomorrow.

Patient Care Summary:
10-27-08 0800
10-27-08 01600
Risk Score:
Breath Score 12
Full Risk: 2
Nutrition Risk: no indicators present
Cognitive Perceptual Neurone: WNL except paraplegia
Pain
Presence of Pain: complaints of pain/discomfort
Location: upper back
Radiation To: shoulders
Pain Rating: 4 on 10
Pain Rating: Activity 8
Nutritional Indicators of Pain: grimace
Comfort/Acceptable Pain Levels 2
Description (frequency/quality): frequent, sharp
Factors that Aggravate Pain: restlessness
Factors that Relieve Pain: medications, repositioning
Respiratory
WNL except diminished breath sounds, lower lobes
Nutrition
Diast/Nutrition Prescription: regular
Diast/Fooding Tolerance: fair
Intake (%): 80%
Fluid: adequate
Musculoskeletal
WNL except no movement of lower extremities
Skin
WNL
Coping
Observed Emotional Status: quiet
Participation/Involvement in Care: brother at bedside

Education Outcome Record:
10-28-08
Neurologic level of injury and impact on neurological/motor function:
(1) partly motor, needs review/practice, individual instruction, patient, family instructed
Adaptive techniques to accomplish ADLs for neurologic level of injury:
(1) partly motor, needs review/practice, individual instruction, patient, family instructed
Skin assessment and pressure relief techniques:
(1) partly motor, needs review/practice, individual instruction, patient, family instructed
Theremoregulation problems and prevention strategies (e.g., appropriate clothing depending on temperature, avoid temperature extremes):
(0) unable to meet; needs instruction, individual instruction, patient instructed
Skin assessment and pressure relief techniques:
(2) meets goals/outcomes, individual instruction, patient, family instructed

Cognitive Perceptual Neurone:
WNL except paraplegia
Presence of Pain:
denos
Respiratory
WNL
Nutrition
Diast/Nutrition Prescription: regular
Diast/Fooding Tolerance: fair
Intake (%): 80%
Fluid: adequate
Musculoskeletal
WNL except no movement of lower extremities
Skin
WNL
Coping
Observed Emotional Status: sad, withdrawn
Verbalized Emotional Status: worried, frustrated
Participation/Involvement in Care: mother at bedside
New Ways to Transition Care

**SBAR**
(Situation, Background, Assessment, Recommendation)

**GOAL:**
Reduce risk of incomplete exchange by providing a process for sharing patient information.

**CPM™ Professional Exchange Report**

**GOALS:**
- Reduce risk of incomplete exchange by providing a process for sharing patient information.
- Provide holistic overview of patient/significant other reflecting the scope of practice.
- Establish prioritization of care for written orders, medical diagnoses, treatments, and human response diagnoses, including patient/professional perspectives.
- Assure mutuality and continuity of individualized care.
- Assure clarity on outcomes as well as the evaluation of progress made towards those outcomes.
- Minimize need for information retrieval by subsequent caregivers.
- Provide time for consultative interchange between accountable caregivers.
Dynamic Network Structure: Post Implementation

Patient Profile

powered by QRA, CASOS Center @ CMU
Thank-You

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CPM Resource Center

CPMRCmichelle

www.clinicaldecisionsupport.com
www.cpmrc.com