CLARITY White Paper

Enhanced Healthcare Effectiveness and Cost Reduction

Driving a New Look at the Adoption of Evidence Based Care

As Dr. David Sackett stated in 1996, EBM "means integrating individual clinical expertise with the best available external clinical evidence from systematic research."

Wouldn't it be wonderful … If we could know with reasonable certainty that what we did in healthcare delivery and patient care was safe, timely, effective, efficient, equitable, and patient centered each time? … If we could help clinicians and administrators easily integrate Evidence Based Medicine (EBM) into daily practice and decision making so that they are truly available to deal with the complex case and practice the art of medicine when the unique situation requires? … If we could measure the impact of our interventions so that we could continue to make sure that the evidence based recommendations are achieving our desired outcomes and for all those circumstances where there is insufficient evidence to support our decisions and to begin to establish evidence?

As Dr. David Sackett stated in 1996, EBM "means integrating individual clinical expertise with the best available external clinical evidence from systematic research." EBM stresses the importance of creating a succinct clinical question that gets to the core of the therapy you are considering for your patient based on the patient's clinical presentation… and using the clinical literature to find the evidence that answers your question most completely. Having gained that knowledge, you can appraise the quality of the studies reviewed and then reapply what you have learned to your individual patient situation to validate that it is the therapy you wish to use. From here you use your clinical judgment to go forward with your plan.

There is a quiet logic to this process, and yet the implementation of EBM in healthcare organizations remains an often daunting and difficult task. The issues emanate from many sources … from the fact that clinicians are not necessarily 'taught' to do EBM … to the inability to

access the therapeutic studies with appropriate Information Technology tools … to the clinician's unwillingness to apply what is learned through the EBM process … to the uncertainty that EBM actually works.

…it might just be time to take a closer look at EBM in both medical and nursing care and extend this concept to Evidence Based Care (EBC.)

Having said this, it might just be time to take a closer look at EBM in both medical and nursing care and extend this concept to *Evidence Based Care (EBC)*. Clinicians do not practice in silos. Therefore, physicians, nurses and administrators need to work together to review evidence and identify ways to incorporate best practices into their daily patient care. Many believe that EBC provides for a consistency of application of therapeutic approaches that can help to control cost, enhance quality, reduce potential allegations of negligence and support patient safety. In the age of the Patient-Centered Care, Healthcare Safety, and the Affordable Care Act with the advent of Accountable Care Organizations, the focus on increasing the use of Evidence Based Care is getting quite sharp.

Gaining any of the positive benefits of EBC noted above, however, requires: collaboration among providers and leadership within organizations to promote EBC; use of the tool appropriately; access to the resources needed to effectively go through the EBC process; support for the clinicians who are using EBC along with holding those accountable who choose not to use the EBC processes decided upon. It is clear that EBC, while not a new process, is a new way to think about blending the high quality clinical expertise of the individual with the research studies that show the value of therapies over larger patient populations in order to gain not only resource efficiencies, but more effective patient outcomes. In addition, the use of EBC may help and can potentially hurt a provider if there is an allegation of medical negligence … for example, what do you think might happen to the clinician and possibly the hospital in this scenario?

The hospital has developed evidence based guidelines for the administration of Fresh Frozen Plasma (FFP). Dr. X believes that FFP is effective despite the lack of evidence to support his belief. The hospital has worked with Dr. X to help him see that his use of FFP is not indicated, but Dr. X continues to order FFP for all his patients. In due

course, Mr. Smith, one of Dr. X's patients, is given FFP, develops hepatitis from the transfusion and dies.

Aspects of medical technology like theories of medical negligence continue to evolve…in this environment, it is best to consider how to best protect the patient AND the provider, which always needs to start with what is in the best interests of the patient.

We are in a *New Age of Healthcare* and it is the time for providers to consider tools that might not have been in their practice 'bag of tricks' or experience before now. BUT … to be successful we must do more than say it is a good idea. Hospital, Medical and Nursing leadership all need to collaborate in order to give Evidence Based Care serious consideration in the context of safe, timely, effective, efficient, equitable, and patient centered care.

Prior to 1983, the most influential physician to a hospital was the physician responsible for the most patient days. Post DRGs, there was a dramatic shift when hospitals realized that those physicians who helped drive revenue in the past may now be costing them millions of dollars if they were not efficiently managing patients. In the era of healthcare reform and Accountable Care Organizations, will there be a power shift to those providers who effectively integrate evidence based care into daily practice?

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