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a working group was established to review the data, identify fixable problems with the highest frequency, and propose changes to improve patient care and efficiency of hospital operations.

**FINDINGS TO DATE/EVALUATION OF WEB SITE:** Over one week, we identified 199 problems in 25 different categories related to the good form consumed 26 minutes of resident time. Problems resulted in 31 delayed dis- charges. Most complaints (72%) were associated with a minor effect on patient care; 26% were associated with a significant effect and 2% with a severe effect on patient care. Seventy-six percent of the problems arose from inefficiencies at the Ward Clerk position.

**KEY LESSONS LEARNED:** A short but intense resident-driven effort to compre- hensively identify problems encountered on the medicine wards was very effective. Collaboration with hospital leadership and commitment of hospital staff to follow up each problem in “real-time” allowed us to determine root causes as well as poten- tial solutions. This detailed information enabled better targeting of limited resources in an effort to create meaningful changes in the efficiency and safety of patient care.

**MODALITY(IES) USED TO DEMONSTRATE INNOVATION AT MEETING:**

**TO STUDY PATIENT SATISFACTION WITH THE USE OF A NURSE-BASED TELE- PHONE PROTOCOL FOR MANAGEMENT OF URI SYMPTOMATOLOGY:** S. Chaudhry1, R. Strobel2, H. VanHouten1, J. Naessens3, S. Scheitel1. Mayo Clinic, Rochester, MN. (Tracking ID #116144)

**STATEMENT OF PROBLEM/QUESTION:** Acute upper respiratory infection is a com- mon, self-limiting viral infectious illness. Patients can be treated by RN telephone protocols for patients with symptoms of viral URI and acute sinusitis. Patient satisfaction with RN telephone management has not been assessed in past.

**OBJECTIVES OF PROGRAM/INTERVENTION/WEB SITE:** To determine if a nurse- based telephone protocol for management of URI and acute sinusitis will result in patient satisfaction equal to usual care.

**DESCRIPTION OF PROGRAM/INTERVENTION/WEB SITE:** January 2002 to July 2002 patients calling with symptoms of cough, runny nose, sinus pain or infection were triaged to a guideline-based registered nurse (RN) telephone treatment protocol (intervention) or usual care (control). Patients of 10 physicians were enrolled in the intervention group, whereas patients of the other 21 physicians received usual care (cluster randomization). Based on protocol questions, the RN determined if the patients’ symptoms were suggestive of viral infection, bacterial sinusitis, or another diagnosis requiring physician evaluation. Symptomatic measures only were suggested for presumed viral infections. Cases of presumed bacterial sinusitis were treated with first line antibiotics (amoxicillin, erythromycin, or sulfamethoxazole/ trimethoprim). Patient satisfaction was assessed by sending all patients in both groups a survey in 30 days of their initial contact.

**FINDINGS TO DATE/EVALUATION OF WEB SITE:** Forty-five out of 77 patients in nurse telephone treatment group (58.4%) and 76 out of 135 patients (56.3%) in the usual care group responded to the survey. 88.9% in telephone group rated the nurse telephone treatment group (58.4%) and 76 out of 135 patients (56.3%) in the usual care group responded to the survey. There was no difference in blood pressure control in both VA and CMC. Outcomes were substantially better for VA study patients than for CMC patients. Commercial plans may benefit from a better understanding of VA quality improvement initiatives. No studies, however, have focused in depth on chronic, outpatient conditions. We sought to compare the quality of diabetes care between patients in VA and those enrolled in CMC organizations using equivalent and pre-specified sampling and measurement methods.

**METHODS:** We enrolled patients with diabetes from 5 VA medical centers (N = 1285) and 8 CMC organizations (N = 6920) in 5 matched geographic regions. We compared scores on 10 identified specifically quality measures (e.g., annual hemoglobin A1c [A1c], annual low density lipoprotein cholesterol [LDL]) and 4 satisfaction measures (e.g., satisfaction with quality of diabetes care), adjusted for patient demographic and health characteristics.

**RESULTS:** VA patients had better scores than CMC patients on all process measures, ranging from a 10 percentage point difference on performance of an annual A1c (93% versus 83%; P = .006) to a 25 percentage point difference on aspirin use counseling (74% vs. 47%; P < .001). There was no difference in blood pressure control between VA and CMC patients, but VA patients had better control of LDL and A1c (86% vs. 72% for LDL; 130 mg/dl; P = .002; 92% vs. 80% for A1c < 9.5%, P < .001). There was a 31% improvement between the two cohorts.

**CONCLUSION:** Our findings show that diabetes processes of care and 2 of 3 intermediate outcomes were substantially better for VA study patients than for CMC patients. Commercial plans may benefit from a better understanding of VA quality improvement programs, especially regarding enhancing LDL and A1c control. However, there was room for improvement in blood pressure control in both VA and CMC.

**A COMPARISON OF THE QUALITY OF MEDICAL CARE MEASURED BY INTERVIEW AND MEDICAL RECORD**

**BACKGROUND:** Chart-based measurement has been considered the gold standard for many measures used to estimate quality of care. However, patients can report on many aspects of their care, including some that may be poorly documented in the medical record, and interview can be a cost-effective data collection method. Using a set of process measures developed for vulnerable older adults, we compared performance scores obtained using data from patient interviews and medical records.

**METHODS:** The Assessing Care of Vulnerable Elders (ACOVE) quality indicators (QIs), a set of 236 explicit process measures covering 22 conditions, were used to assess care in a random sample of vulnerable older adults from two senior managed care plans. Data were available from both interview and medical records for 245 patients. 60 QIs were measured with data available from both sources. We performed a priori classification of the “gold standard” data source for the 60 QIs as follows: Interview better source for 21 QIs; medical record better source for 24 QIs; both were better sources for 15 QIs; neither was a better source for 6 QIs. The gold standard would be a better source for QIs measuring routine medical procedures (14 QIs); the remaining 30 QIs had no preferred data source. Performance scores were compared using the percentage of observed care that met the criterion of good care, and medians and interquartile ranges were calculated for both data sources.

**RESULTS:** Performance assessed by the 30 quality indicators without a preferred data source scored the same by interview 66% (95% CI, 64% to 68%) and medical record 65% (95% CI, 64% to 67%). Quality of care measurement by the 14 QIs for which interview was the a priori preferred had a much higher mean quality score by interview 66% (95% CI, 63% to 68%) than medical record 30% (95% CI, 27% to 37%).