An Implementation Framework for Patient Safety in Ambulatory Care

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Objectives

• To disseminate key findings from IHI’s work on ambulatory safety

• To share the path IHI and Northwell Health have been on to provide infrastructure to ambulatory patient safety

• To review the IHI Framework for Clinical Excellence and discuss its applicability to the Primary Care and Specialty Care settings

• To review IHI’s experience testing with four Northwell Health Ambulatory care sites
Joint Efforts

- In October 2015, IHI, NPSF and Northwell Health came together with an aim to generate and test some actionable recommendations for ambulatory patient safety
- Northwell Health, as part of our Strategic Partnership, was asking how to operationalize patient safety with different models of ambulatory practices (Employed, Affiliated, Urgent Care, Joint Ventures)
- Faculty, Leaders of Healthcare Organizations, Staff and Patient Feedback

Expert Meeting Outputs

- Culture and Burnout
- Continuity of Care
- Standardization
- Team Based Care
Framework For Safe and Reliable Care

- Creating an environment where people feel comfortable and have opportunities to raise concerns or ask questions.
- Being held to act in a safe and respectful manner given the training and support to do so.
- Facilitating and mentoring teamwork, improvement, respect and psychological safety.
- Developing a shared understanding, anticipation of needs and problems, agreed methods to manage these as well as conflict situations.
- Openly sharing data and other information concerning safe, respectful and reliable care with staff and partners and families.
- Gaining genuine agreement on matters of importance to team members, patients and families.
- Applying best evidence and minimizing non-patient specific variation with the goal of failure free operation over time.
- Regularly collecting and learning from defects and successes.
- Improving work processes and patient outcomes using standard improvement tools including measurements over time.
- Openly sharing data and other information concerning safe, respectful and reliable care with staff and partners and families.

Our Focus on the Learning System

- Safety
- Leadership
- Teamwork & Communication
- Transparency
- Engagement of Patients & Family
- Negotiation
- Reliability
- Improvement & Measurement
- Continuous Learning
- Learning System

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Model for Improvement

What are we trying to accomplish?

How will we know that a change is an improvement?

What changes can we make that will result in an improvement?

Different Setting, Different Approach

Starts with one unit, practice or SNF unit and Improvement Capability

- Give the experts (the staff) access to the tools for improvement
- Let them explore their “biggest rocks” or daily frustrations
- Leadership must support their efforts and remove barriers to improvement
- Improvement should be a positive experience
- Data collected and improvements made are then linked to safety
- New teams start new improvement cycles - learning system begins
- After successful improvement cycles demonstrate increased workflow, reliability and joy in work, the system can then test the team on more challenging “safety” problems using tools like Primary Care Trigger Tool.
Identifying Safety Issues

Identifying Safety Issues and Challenges in your practice

Northwell is very committed to understanding what matters to you in SAFETY at your primary care, specialty care and urgent care. We would like to think about aggregating front line concerns into an execution framework for Patient Safety outside of the hospital.

Instructions: Speak with your staff about challenges and issues they are experiencing in their day to day work that may impact patient safety and document them on this chart. Make sure to include your whole team, including but not limited to physicians, nurses, medical assistants, administrative staff, phlebotomists and lab technicians. Feel free to ask patients as well about safety concerns they might have. THANK YOU!

Please return this sheet to denise.edwards@thi.org.

Title Name and Location ________________________________

Contact Email ________________________________

<table>
<thead>
<tr>
<th>Challenge/Issue</th>
<th>How often do you experience this issue?</th>
<th>What severity of harm does the issue cause to patients?</th>
<th>Does this issue cause staff frustration?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Daily/Weekly/Monthly/Annually</td>
<td>Minor/Moderate/Serious</td>
<td>Rarely/Regularly/Frequently</td>
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Touchpoints with Northwell Sites

- **Virtual touchpoints**
  - 4 All-team Webinars (6/17, 7/22, 8/26, 10/28)
  - Individual Coaching Calls (3 per team)
  - Follow-up emails in between each webinar and coaching call

- **Topics Covered**
  - Model for Improvement
  - Developing an Aim Statement
  - Measurement and Data Collection
  - Running a PDSA Cycle
  - The IHI Patient Safety Framework

- **Resources Shared**
  - Grid to track safety concerns
  - White board videos on flow mapping and run charts
  - PDSA planning form
  - Slide deck template for teams to track progress
Northwell Health

About Northwell Health

- Northwell Health System is based in Long Island NY, with hospitals and practices across the greater New York area.

- The system contains 21 hospitals and 3 skilled nursing facilities. The network has over 12,000 member physicians.

- Northwell Health Physician Partners employs nearly 2,700 full-time physicians and offers nearly 400 regional ambulatory locations and physician practices, including urgent care.
Northwell Ambulatory Pilot Sites

- **Adult Medicine**: Division of Geriatric and Palliative Medicine, Great Neck, NY
- **Ophthalmology**: Manhattan Eye, Ear and Throat Hospital, New York, NY
- **Pediatrics**: Division of General Pediatrics, New Hyde Park, NY
- **Urgent Care**: Bethpage Urgent Care Center, Bethpage, NY

Bethpage Urgent Care

- **Problem**: Up to date Demographic data is not always available on all patients making it difficult to follow with results, follow up or transfer of care

- Achieve 100% follow up by fax to PCP for all patients with 3 or more Co-morbid conditions within a 3 month time frame

- 6 months in with data and 3 tests of change
Tests of Change

Role Clarity in collecting the data – Front Administrator

Standard work (new form) to track patient demographics and if patient has comorbidities.

Tested faxing over the discharge instructions to the Patients PCP in an attempt to close the loop in follow up with the patient.

Data: Run Charts
General Pediatrics

Problem: Patients getting the wrong vaccine.

Aim: During the period of March 1, 2016 to September 30, 2016, Division of General Pediatrics - IHI site leaders intend to re-align key immunization workflows by navigating through existing AEHR system design for pediatric patients receiving various childhood immunizations so that we can achieve an improvement in the current vaccine reconciliation by 25% by:

1. placing immunization order correctly at the time of visit
2. documenting clinical and non-clinical administration information at the time of visit
3. reconciling order prior to signing note and dropping charges within 24 hour period
4. if immunization schedule is outside of recommended schedule, MD, RN, or Resident documents what is due at the next visit

Next Steps

1. Bar Code System is planned for the future
2. Use role-play scenarios to identify flow failures
3. Restructuring workflow design to support Provider and RN workflow as the key workflow in conjunction with policy and procedure development, physical environment changes, and staffing support
Geriatric & Palliative Medicine at Great Neck

Problem - Lack of documentation of patient end of life wishes and advanced care planning (25-30% of patients had the information documented in the right place)

Aim - Increase advanced care planning documentation, in agreed-upon place in EHR, by 95% in 5 months

Test – adding advanced care planning to Pre-visit checklist

Data: Run Charts

[Run Chart Image]
Northwell Health Physician Partners Ophthalmology at MEETH
Hospital Based Quality Program
MANDATED BY TJC, State & Fed Regulations

- PICG – Performance Improvement Coordinating Group
- Departmental PI – PDSA methodology
- Collaborative Care Council (CCC)
- Patient Safety Rounds
- Educational programs
- Dashboard metrics
- Perioperative committee
- RCAs, Debriefs, Huddles

Hospital Based Quality Program
Who is accountable?

- Director of Quality - RN
- Medical Director - MD
- PICG Chair - MD
- Executive Director
- Individual managers, supervisors, directors
- Health system collaboration and oversight
Ambulatory Clinical Practice Barriers to Quality Programs

- Practice management vs practice quality
- Lack of education in quality improvement methodology
- Lack of structure/support
- Changes usually implemented by opinion without analysis
- Physicians more comfortable with RESEARCH than QUALITY IMPROVEMENT

Opportunity

- Educate ambulatory practice team members on quality improvement
- Identify areas of opportunity
- Use PDSA methodology to test changes
- Broaden scope across practices locally or regionally
- Develop internal metrics and enhanced dashboards to monitor
Our Improvement Team

- Dr. Stephen Obstbaum, Medical Director for Quality-Ophthalmology
- Victoria Leo, Practice Admin Manager
- Dr. Celso Tello, Chairman of Ophthalmology
- Dr. Sung Chul Park
- Dr. Jung Lee
- Dr. Jason Chen
- Adela Moya, Practice Business Manager

Our Improvement Area

- Direct focus on our large glaucoma patient population
- Concerns due to poly-pharmacy and compliance
- No standard process for prescription refills
Baseline Data

- EMR implemented on 5/17/2016
- Utilized tasking report to establish baseline data for prescription refills requested at times other than at the patient’s appointment
- 231 unique medication requests via patient calls were created in that 14 day window.

Aim Statement

- Reduce the need for patients to call in for medication refills by 20% 4 months after initiating the process.
Measures

Process Measures: multi-strategy approach
- Patients were prompted by technicians to describe how they were taking their medications
- Patients were asked if they needed refills (a “Y” response prompted a refill)

Outcome Measures:
- Patient not able to appropriately describe their medication regimen alerted the physician to review the prescribed medications and provide the Medication Instruction Sheet
- Refills of the medication were completed at the time of the visit.
  
  There is increasing evidence that compliance and adherence is improved when all the medications are refilled at the same time.

Syncing Up Drug Refills: A Way To Get Patients To Take Their Medicine

By Shefali Luthra | August 8, 2016

You have your red pill and your green pill. There’s the one you take at breakfast, the one you take before bed and the one you have to take six hours after eating. All said, it is a lot to keep track of. And remembering the refills, all of which often happen at different times of the month, gets so complicated that sometimes you forget — and simply go without.
Mapping the Process

1. **Established Patient**
   A. "How are you taking your medications?"  
      - Adherent
      - Non-Adherent
    1. Medical regimen unchanged?
       - Yes
          - Confirm sufficient medications and the next visit
       - No
          - Adjust medications and the next visit
    2. Restart discussion with patient regarding adherence
   B. "Do you need to have your medications refilled?"
      - Yes
        - Prescribe medications
      - No
        - Confirm sufficient medications until the next visit

2. **New Patients**
   - Naive patient
     - If initiating prescription
       - Sample medications to prescribe
     - Same process as for established patients (A & B)
   - Patient already on medications
     - Provide medication instruction sheet
     - Return Visit: IOP check, tolerance, questions
Next Steps

- Continue to monitor the medication refill requests other than those completed at the time of the appointment.
- Support the staff in the effort as it improves efficiency and reduces the number of extraneous calls throughout the course of the day.
- Continue surveillance of patient adherence at their upcoming appointments using the signed medication instruction sheet.
Broader picture

- Expand program to all physicians in practice
- Expand program to other NHPP practices
- Use program as a model to stimulate new quality programs in our practices
- Develop better quality measures to track results
- Designate a quality leader – RN, MD, admin or team

Thank you

- IHI
- Northwell Health
- Northwell Health Physician Partners
- Glaucoma team
What of this resonates with you?

- Would this approach work in your organization?
- What barriers might you experience?
- What do you think your team’s patient safety concerns might be?

Questions?