Safe Care Across the Health Care Continuum – Primary Care

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This presenter has nothing to disclose.
Activity Time – What would it take?
Objectives

• Discuss the state of Ambulatory Patient Safety and Quality.
• Discuss the harms associated with primary and specialty care.
• Define the challenges that Ambulatory Practices face in defining a reliable path for safety.
Framework For Clinical Excellence

How it works in real life

- Patients more Responsible for Care
- Higher Volume of Patients
- Staffing Mix Job Scoping Issues
- Differing EMRs from Acute Care & Specialists

Culture
- Leadership
- Psychological Safety
- Continuous Learning
- Accountability
- Improvement and Measurement
- Teamwork and Communication
- Negotiation
- Reliability
- Transparency

Investment in Safety and Quality
- Offsite Laboratories & Imaging
- Financial Incentives to Quality Metrics

Learning System

Financial Incentives to Quality Metrics
What Setting? Ambulatory Patient Safety

• Primary and Specialty Care Practices
• Urgent Care
• Ambulatory Surgical Centers
• Dialysis Centers
• Imaging Centers
• Oncology Centers
Case for Further Patient Safety Investment into Ambulatory Care
Parts of a Health System

<table>
<thead>
<tr>
<th>Setting</th>
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<tbody>
<tr>
<td>Primary/Specialty Care</td>
<td>Healthcare Spending (in billions)</td>
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<tr>
<td>Hospital</td>
<td>603.7</td>
<td>971.8</td>
<td>238.8</td>
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<tr>
<td>Post-Acute Care</td>
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Ambulatory Visits outnumber Hospital Discharges 30:1

Patient Safety and Quality in Ambulatory Care, Emily Fondahn and Michael Lane
Modern Healthcare, Tejal Ghandi
http://www.modernhealthcare.com/article/20160305/MAGAZINE/303059979
## Parts of a Health System

### Windows of Harm

<table>
<thead>
<tr>
<th>Delayed Diagnosis</th>
<th>Outpatient falls</th>
<th>Antibiotic resistance</th>
<th>Poor coordination of care</th>
<th>Inability to address social barriers to best health</th>
<th>Medications</th>
<th>Access</th>
<th>Overuse</th>
<th>Infection, Surgical complications</th>
<th>High Risk Medication</th>
<th>Handovers</th>
<th>Pressure Ulcers</th>
<th>Deconditioning</th>
<th>Infection</th>
<th>Medications</th>
<th>Readmissions</th>
<th>Pressure Ulcers</th>
<th>Falls</th>
<th>End of Life</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delays in Diagnosis</td>
<td>12 Million Adults</td>
<td>Per Year</td>
<td>GTT</td>
<td>40% in Every 100 admissions</td>
<td>GTT</td>
<td>22% (with &gt;50% preventable)</td>
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### Adverse event data

| Delays in Diagnosis - 12 Million Adults a Year, GTT | 40% in Every 100 admissions, GTT | 22% (with >50% preventable), GTT |

### Safety Infrastructure

| PCMH | 15+ Years of Learning, Research and Infrastructure into the Acute Care Setting | Hospital Structure for Quality and Safety | Patient Safety Officers | Reporting Systems | Quality Improvement Teams | 5 Star Rating | QAPI |

[Image of a hospital building with a red cross on it]
Safety is a Dimension of Quality

1. Optimal care and adherence to standards
2. Compliance with standards - ordinary care with imperfections
3. Unreliable care/poor quality - The patient escapes harm
4. Poor care with probable minor harm but overall benefits
5. Care where harm undermines any benefits obtained

Paying for Quality but Missing Safety

Prevention Measures
Coronary Artery Disease
Heart Failure
Diabetes
Asthma
Depression
Prenatal Care
Quality Measures Addressing Overuse and Misuse

The Ambulatory Care Quality Alliance Recommended Starter Set

More than half of annual paid medical malpractice claims were for events in the outpatient setting, and two-thirds involved major injury or death.
Safety Challenges Specific to Ambulatory
IHI Expert and Customer Interviews 2014

- Foundations for safety not present - infrastructure and insufficient metrics to help systems understand their biggest safety issues
- Limited resources and many more moving parts; lack of alignment on priorities
- Care not organized around the patient experience, with its numerous interactions with the care system
- Both medical and non-medical determinants are safety challenges
Patient’s Perceptions of Harms

Patients are aware of mistakes in ambulatory care

- 15% of primary-care patients reported that a physician had made a mistake
- 13% reported a wrong diagnosis
- 13% reported a wrong treatment
- 14% changed physicians because of a mistake.
Burnout, Staffing Mix and Role Clarity

In 2015, 46% of physicians up from 40% experiencing burnout. Doctors are 15 times more likely to burn out than professionals in any other line of work.

What Are the Causes of Burnout?

- Too many bureaucratic tasks: 4.74
- Spending too many hours at work: 3.99
- Income not high enough: 3.71
- Increasing computerization of practice: 3.68
- Impact of the Affordable Care Act: 3.65
- Feeling like just a cog in a wheel: 3.54
- Too many difficult patients: 3.37
- Too many patient appointments in a day: 3.34
- Inability to provide patients with the quality care that they need: 3.22
- Lack of professional fulfillment: 3.05
- Difficult colleagues or staff: 2.9
- Inability to keep up with current research and recommendations: 2.86
- Compassion fatigue (overexposure to death, violence, and/or other loss in patients): 2.8
- Difficult employer: 2.8
Burnout, Staffing Mix and Role Clarity

- Nurses spend the majority of time on the phone (in triage)
- Nurses are more expensive so Medical Assistants (MA) are more commonly used to support physicians
- MA Scope of duties – Administering vaccines
- Disrespect and not using to their top of their abilities
Challenges

**Time** - primary care physician would spend 21.7 hours per day to provide all recommended acute, chronic, and preventive care for a panel of 2,500 patients

**Leadership Structure** – Supporting structures such as Ambulatory Safety and Quality Leadership who are owners of the Learning System.

*Justin Altschuler, MD, 2012*
Progress?
Tools for Primary Care Patient Safety

- A study aimed to identify tools that can be used by family practitioners as part of a patient safety toolkit.
- 114 tools were identified (mostly from the US and UK) on themes such as medication error, safety climate, adverse even reporting, informatics, patient role, and general measures to correct error.
- Few specific tools for primary care exist. Diagnostic error and results handling appear infrequently despite their relative importance.
- Many of the tools have yet to be used in QI strategies and cycles such as plan–do–study–act (PDSA) so there is a dearth of evidence of their utility in improving as opposed to measuring and highlighting safety issues.

Source: Tools for primary care patient safety: a narrative review; Rachel Spencer and Stephen M Campbell
Patient Centered Medical Home

Delivery Model Focused on these core components:

- Comprehensive Care
- Patient Centered Care
- Coordinated Care
- Accessible Care
- Quality and Safety
Impact of ACOs

- Accountable Care Organizations (ACOs) – taking financial risk for a subset of patients
- ACOs are relatively easier to implement and have advantage of reducing high cost services but require much more complex negotiations among groups
- ACO approach is focused on expanding the role of primary care for preventative care
Types of Harms – Primary Care
# Ambulatory Harms

## Common Harms in Ambulatory Care

<table>
<thead>
<tr>
<th>Harm</th>
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<tr>
<td>Delayed Diagnosis</td>
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<td>Medications</td>
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<td>Coordination of Care</td>
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<tr>
<td>Access</td>
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<td>Overuse</td>
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</table>
Where do we begin to Improve?
Chhannngesss……

Small Changes
• Start Talking about Safety gaps
• Huddles

Bigger Changes
• Leadership Structure
• Identifying data for safety Improvement
• Time to use Improvement to Improve
Ask your teams!

**Identifying Safety Issues and Challenges in your Practice**

IHI 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 lenoci-edwards@ihi.org.

Site 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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Good Starting Place - Huddles

Huddles impact every part of the framework, culture and the learning system.

Start huddles with a small bit of work and grow the work as the team gains proficiency. Teams determine the aim of the huddle. For example, in their huddles, teams can discuss what patients on the schedule are unlikely to show up for their appointments (because they are in the hospital, they called to cancel, or were seen just last week), what equipment will be needed in the room, and what additional services the care team can provide for the patient at today’s appointment to make a re-visit less likely. **Lessons learned from the huddles are recorded and reviewed at weekly team meetings.** (Learning System)

Weekly team meetings review lessons from huddles. **The care team also needs concentrated time together to plan their roles and responsibilities, as well as to discuss opportunities for improvement in their work.** Planned team meetings, scheduled weekly or monthly, are the most effective tool for accomplishing these types of important activities. (Culture)

http://www.ihi.org/resources/Pages/Changes/UseRegularHuddlesandStaffMeetingstoPlanProductionandtoOptimizeTeamCommunication.aspx
Where to Improve?
Data Reporting or the Trigger Tool

- Sample of 500 records found an adverse event rate of 9.4% (47) of which 42% were deemed preventable.
- 59% were medication related
- Now the TT is helping primary care teams identify areas for improvement

## Ambulatory Harms

| Delayed Diagnosis | • 5 percent of U.S. adults in outpatient care each year experience a diagnostic error  
|                  | • Postmortem examination research spanning decades has shown that diagnostic errors contribute to approximately 10 percent of patient deaths  
| Medications      | • Furthermore, diagnostic errors are the leading type of paid medical malpractice claims and are almost twice as likely to have resulted in the patient’s death compared to other claims.  
| Coordination of Care |                  
| Access           |                  
| Overuse          |                  |
Complicated…but Actionable
### Ambulatory Harms

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</table>
| **Delayed Diagnosis** | • Median prevalence rate of ADEs in primary care patients was 12.8%  
• Patients with polypharmacy are more at risk  
• Feedback to clinician after an event has occurred  
• Better communication between physicians for complicated patients before prescribing a medication  
• EMRs  
• What matters to you? |
| **Medications**   |                                                                                                                                                                                                 |
| **Coordination of Care** |                                                                                                                                                                                                 |
| **Access**        |                                                                                                                                                                                                 |
| **Overuse**       |                                                                                                                                                                                                 |
Objectives

• Discuss the state of Safety and Quality in the Post Acute Setting
• Discuss the harms associated with the Post Acute Setting
• Define the challenges that these settings face in defining a reliable path for safety
Framework For Clinical Excellence
How it works in real life

- Frail Elder Patients
- Family Complexities
- Employee Competency
- Leadership
- Psychological Safety
- Continuous Learning
- Accountability
- Improvement and Measurement
- Teamwork and Communication
- Negotiation
- Reliability
- Transparency

- Multiple Comorbidities
- End of Life Issues
- Serious Financial Constraints
- Medical Director Responsible for many patients
What Setting? Post Acute Settings

- Rehabilitation Centers
- Skilled Nursing Facilities
- Long Term Care Facilities
- Home Health
Parts of a Health System

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| Healthcare Spending (in billions) | 603.7 | 971.8 | 238.8 |

Hospital: [http://www.cdc.gov/nchs/fastats/hospital.htm](http://www.cdc.gov/nchs/fastats/hospital.htm)
Post-Acute: [http://www.aha.org/research/reports/tw/10nov-tw-postacute.pdf](http://www.aha.org/research/reports/tw/10nov-tw-postacute.pdf)
Patient Safety and Quality in Ambulatory Care, Emily Fondahn and Michael Lane: [Modern Healthcare](http://www.modernhealthcare.com/article/20160305/MAGAZINE/303059979)
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<th>Falls</th>
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<td>Surgical Complications</td>
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| Adverse event data | Delayed Diagnosis - 12 Million annually | 40% in Every 100 admissions* | 22% (with >50% preventable)** |

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<td>Hospital Structure for Quality and Safety</td>
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<td>Patient Safety Officers</td>
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<td>Reporting Systems</td>
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<td>Quality Improvement Teams</td>
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<td>Nursing Home 5 Star Rating</td>
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<td>QAPI</td>
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*Global Trigger Tool

**SNF Trigger Tool
Defining a Skilled Nursing Facility (SNF)

- **Skilled nursing care and rehabilitation** for Residents who require care due to injury, disability, or illness
- Approximately **16,000** SNFs nationwide
Second most regulated Industry

- Second to Nuclear Industry
- 130,000 pages of federal regulations
- National and Local Laws
- Overall Quality Rating based on metrics in three areas
  - Health Inspections
  - Staffing
  - Quality

Nursing Home Compare Metrics

Percentage of residents who/whose:

- need for **help with activities of daily living** has increased
- **ability to move** independently worsened
- with **pressure ulcers** (sores)
- have/had a **catheter inserted and left in their bladder**
- were **physically restrained**
- with a **urinary tract infection**
- self-report moderate to severe **pain**
- experienced one or more **falls with major injury**
- received an **antipsychotic medication**
- physical function **improves from admission to discharge**
- were **re-hospitalized after a nursing home admission**
- have had an **outpatient emergency department visit**
- who were **successfully discharged to the community**
Case for Further Patient Safety Investment into Post Acute Care
Financial Impact of Care

“Nursing-home finances are a careful balance between money-losing Medicaid patients and profitable Medicare and private-pay patients. That’s why nursing-home operators are concerned that a string of new facilities—about 20 in the past five years—has been aimed almost exclusively at the profitable Medicare and private-pay patients.”
SNFs: Adverse Events in Skilled Nursing Facilities: National Incidence Among Medicare Beneficiaries

- An estimated 22% of Medicare beneficiaries experienced adverse events during their SNF stays.
- An additional 11% of Medicare beneficiaries experienced temporary harm events during their SNF stays.
- Physician reviewers determined that 59% of these adverse events and temporary harm events were clearly or likely preventable. They attributed much of the preventable harm to substandard treatment, inadequate resident monitoring, and failure or delay of necessary care.
- Over half of the residents who experienced harm returned to a hospital for treatment, with an estimated cost to Medicare of $208 million in August 2011. This equates to $2.8 billion spent on hospital treatment for harm caused in SNFs in FY 2011.
Turnover and Staffing Mix

- Medical Director may oversee many Nursing Homes
- Mix of Registered Nurses, Licensed Practical Nurses and Certified Nursing Aides
- Many studies have associated turnover in SNFs to less quality care and poor continuity thereby impacting the mental health of the residents.
- SNF turnover of nursing staff and certified nursing aids have spanned 50-75% for decades and that trend continues to be a challenge for many settings

Makamul et al 2010
Cohen-Mansfield, 1997
Progress?
Policy Changes: CMS Adds New Quality Measures To Nursing Home Compare

- 3 of the 6 new quality measures are based on Medicare-claims data submitted by hospitals. This is the first time CMS quality measures are not based solely on self-reported data by nursing homes.
- The 3 measures measure the rate of rehospitalization, emergency room use, and community discharge among nursing home residents.

https://www.sciencedaily.com/releases/2016/04/160419120102.htm
Bundled Payments

- Expected costs for evidence based management of clinically based care – Institution receive a lump sum for that care Builds on Diagnosis Related Group; combines physician and post-acute services with hospital care (90 days post).

- Early savings appear to exist by rationalizing post-acute care, and potentially more efficient use of physician services
ACO – Priority Networks

- Accountable Care Organizations are held to a variety of measures including readmissions
- For readmissions, there has been a push to create a preferred provider network of SNF providers
- The goal is for the Acute Care Hospitals to partner with the SNF to achieve quality, efficient management of the patient in the post acute
QAPI
Quality Assurance Performance Improvement

Currently Being Piloted in Nursing Home

Five Components of QAPI

• Design
• Leadership
• Feedback Data Systems and Monitoring
• Performance Improvement
• Systematic Action
Types of Harms – Post Acute
# Post Acute Harms

## Common Post Acute Harms

- Falls
- Pressure Ulcers
- Medications
- Infection
- End of Life
- Readmissions
Where do we begin to Improve?

Transparency
Leadership
Psychological Safety
Accountability
Teamwork & Communication
Negotiation
Transparency
Reliability
Improvement & Measurement
Continuous Learning
Engagement of Patients & Family
The Key - Competency, Respect and Turnover

- The Post Acute Setting has infrastructure and regulation, even the beginnings of quality improvement
- Challenge areas Identify Safety Issues – Staff turnover due to respect, role clarity, and competency
- Starts with teamwork, just culture and clinical competence of the team
- Teamwork that includes the Physician, Nurses and Certified Medical Assistants
Skilled Nursing Facility Trigger Tool

Identifying Areas of Improvement

IHI Skilled Nursing Facility Trigger Tool for Measuring Adverse Events
## Ambulatory Harms

| Delayed Diagnosis                                                                 | • Multiple providers managing different parts  
|-----------------------------------------------------------------------------------|------------------------------------------------|
| Medications                                                                       | • Social needs not being addressed  
| Coordination of Care                                                               | • Sick or Fragile patients responsible for coordinating care  
| Access                                                                            | • EMRs                                          |
| Overuse                                                                           |                                                 |
### Ambulatory Harms

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<tbody>
<tr>
<td>Delayed Diagnosis</td>
<td>• Patients not able to get the right care at the right time</td>
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<tr>
<td>Medications</td>
<td>• Patients deteriorate waiting for care</td>
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<tr>
<td>Coordination of Care</td>
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## Ambulatory Harms

<table>
<thead>
<tr>
<th>Category</th>
<th>Examples</th>
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<tbody>
<tr>
<td>Delayed Diagnosis</td>
<td>• Unneeded tests or imaging that cause anxiety</td>
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<tr>
<td></td>
<td>• Invasive testing</td>
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<td>• Unnecessary Antibiotics lead to Antibiotic Resistance</td>
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<td>• Increased radiation exposure</td>
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<td>• Costs</td>
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<td>• Increased procedures exposure to potential harms</td>
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<td>Medications</td>
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