



# IMA INSIGHTS

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## HOW SAFE ARE PATIENTS IN YOUR PHYSICIAN PRACTICES, NETWORK, AND AMBULATORY CARE CENTERS?

To our Healthcare Clients and Friends:

In this edition of *IMA Insights*, we will discuss patient safety, which represents a significant public health issue. Concerns that tight financial margins may impact care quality fuel its prominence in the public eye. Initially, patient safety programs focused on acute care providers. But, physicians' offices, networks, and ambulatory care centers (ACCs) provide the majority of healthcare, a shift from inpatient to outpatient that will continue. Moreover, these settings comprise growing portions of hospitals' and health systems' business portfolios. As patients become savvier about patient safety and quality issues, a practice's failure to resolve these concerns will erode patient volumes and profitability.

Most commonly, errors in physician offices and ACCs arise from miscommunication and inadequate systems for managing ordered tests and their results. The ensuing missed diagnoses lead to increased malpractice claims and coverage costs, as well as litigation expense. As the Center for Medicare & Medicaid Services (CMS) continues to expand Physician Quality Measures, practices and ACCs with strong patient safety and quality programs will realize higher reimbursement for services provided.

This *IMA Insights* article describes the initial phase of a Patient Safety Program implemented in a group of diverse physician practices.

### KEY ISSUES AND CHALLENGES

In 1999, the Institute of Medicine (IOM) released its landmark report, *To Err Is Human: Building a Safer Health System*, bringing national attention to the serious problem of errors in healthcare. Since the time of this report, organizations have launched dramatic efforts to improve patient safety. Most progress has occurred in the acute care setting. However, addressing patient safety at all levels of the healthcare system remains a challenge, as significant opportunities for improvement in physician practices and ambulatory settings continue to exist.

Organizations such as The Joint Commission and The Agency for Healthcare Research and Quality (AHRQ) have evaluated and researched patient safety or medical errors. Although The Joint Commission provides national patient safety goals, each healthcare organization has the responsibility to define a culture of safety and the corresponding approaches to preventing medical errors, reducing adverse outcomes as a result of them, and improving the safety and quality of patient care.

#### *What does this mean?*

In a culture of safety, staff are encouraged to work towards change and to take action. In such an environment, all levels of the organization assume responsibility and accountability for patient safety. Organizations can improve safety when staff is enabled to share information openly and leaders commit to change. An assessment of an organization's culture regarding safety represents an invaluable initial step to determine the presence of a culture of safety. This baseline data promotes a transition to a culture that enables reporting of adverse events and unsafe conditions into daily work without fear of reprisal and ultimately to improving the quality of care.

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### *How did a Specialty Practice develop a Patient Safety Program?*

Recognizing the critical importance of a strong patient safety culture and practices that optimize safe patient care, 15 specialty physician practices implemented a Patient Safety Program which included the following goals:

- Quantify the patient safety culture through administration and result analysis using the Institute for Healthcare Improvement's Safety Climate Survey (IHISCS).
- Identify self reported compliance and improvement opportunities, as noted in the Outpatient Patient Safety Assessment, Part I (OPSA).
- Develop an 18 month patient safety plan.

As a result of this assessment, the practices launched a Patient Safety Program. Multiple communication approaches and clearly articulated strategies to support confidentiality resulted in 87 percent of eligible employees (including providers) completing both surveys. Survey responses supported a strong Patient Safety Climate and very high compliance with safety procedures (as queried in the OPSA). Compliance scores exceeded 85 percent for all areas. Given the potential that the halo effect and respondent bias may have influenced OPSA results, the study deemed compliance scores of less than 90 percent as opportunities for improvement. Not surprising, these areas included: patient identification (using two identifiers for each patient); hand hygiene; communication among staff members (abbreviation use, provider and office staff communication, phone call documentation). Importantly, responses suggested that a "no blame" culture could be strengthened.

Based on combined IHISCS and OPSA results, improvement plans were developed. Specifically, practice changes included:

- Refined policies, ensuring consistency with patient safety initiatives. These evidence-based best practices would include: phone call management, infection control, test and lab report tracking.
- Strengthened patient safety communication through multiple approaches including, but not limited to, laminated cards, newsletters, email, practice site posters, and staff meetings.
- Verified that staff knew and followed safety policies.
- Implemented a standardized hand hygiene blitz to include educational posters, with required post test completion and validation that needed supplies, such as soap, towels, and hand rubs are readily available.
- Provided education and role modeling for front line managers to ensure they possessed the knowledge and skills to reinforce a "no blame" culture and to implement root cause analysis techniques.
- Re-administered the Safety Climate Survey and Part II of the OPSA in 12-18 months.

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### INSIGHTS: TRANSLATING THE RESULTS TO YOUR PRACTICES

As you contemplate how these results apply to your practice settings, consider the following:

Each office must evidence a culture in which staff can openly identify problems. The IHISCS (a 19 item, Likert survey) can provide baseline data about staffs' perceptions of the safety culture. The IHISCS measures critical dimensions related to leadership, communication, reporting, policy and procedure, and staffing.

In conjunction with a Safety Climate/Culture Assessment, practices should determine compliance with best office safety practices. Initially, this evaluation should focus on The Joint Commission's safety goals. The following questions may help target areas for assessment.

- Does staff always use two patient identifiers, for example name and social security number or name and birth date? (First and last name "count" as only one identifier).
- Do caregivers have the medical record in front of them when relaying patient information (or making decisions about care)? This includes any patient related phone calls.
  - Is each phone call documented?
  - Do practice staff "read back" instructions from the provider? (A "read back" is predicated on having the instructions documented).
  - Are these written instructions included in the medical record? Are they reviewed and initialed (co signed) by the provider?
- Are abbreviations used in the office medical record?
  - Do you use the abbreviations in office records or in "orders" to other clinical staff? Do you use "unwanted/forbidden" abbreviations as provided by The Joint Commission?
- Does your practice assure each ordered test is done and that results are received and communicated to the patient?
  - Can you validate that patients had each ordered test?
  - Can you assure that you received all test and lab results? Does a provider sign or initial each report after review?
  - Is every result communicated to the patient (whether positive, negative, or equivocal)? Is this discussion noted in the medical record?
- Do you provide medications in your practice?
  - Do you use "look-alike" drugs? If, so, how are they separated?
  - How are sample medications documented and tracked?



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- If you follow patients on anticoagulant therapy, how do you track their dose, lab results, and therapy changes? Do you know how many of your patient’s are “in range?”
- Do you have a system to follow-up when patients with chronic conditions are “no shows?” Is this follow-up documented?

Open communications, education, monitoring of results, and collaborative planning play essential roles in supporting this cultural shift. Changes in behaviors will occur only in environments that foster those changes. The end result will be improved quality of care and positioning for enhanced reimbursement.

**SUMMARY**

Patient Safety Climate Surveys and best practice compliance assessments, such as (OPSA) provide critical insights into improvement opportunities in physicians’ offices, networks, and ACCs. The continued shift to outpatient services, increased public knowledge of safety and outcomes, and changes in reimbursement have created the need for physicians’ offices, networks, and ambulatory care centers (ACCs) to enable a culture of safety. Further, as CMS continues to expand Physician Quality Measures, practices and ACCs with strong patient safety and quality programs will realize higher reimbursement for services provided. Leaders must focus their attention to patient safety initiatives in the non-acute environment to enhance practice volume, revenue, expense avoidance, and promote quality care.

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We are pleased to have had the opportunity to provide this information to you. If you have any questions or would like to discuss ways in which these physician practice initiatives can improve the performance within your practice or network, please do not hesitate to contact me at 610.659.9530.

Yours very truly,

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