Today’s Host

Gonzalo Garrido-Lecca
Latin America Region Project Assistant
Institute for Healthcare Improvement
Phone Connection (Preferred)

To join by phone:
1) Click on the “Participants” and “Chat” icons in the top right hand side of your screen.
2) Click the button on the right hand side of the screen.
3) A pop-up box will appear with the option “I will call in.” Click that option.
4) Please dial the phone number, the event number and your attendee ID to connect correctly.
WebEx Quick Reference

- Please use chat to “All Participants” for questions.
- For technology issues only, please chat to “Host.”
Chat

Questions about previous sessions or action period assignments?

Please send your message to All Participants
Expedition Sessions

Session 1 – Setting the Stage for Ambulatory Patient Safety
Session 2 – Where Are You in the Journey and Where to Begin?
Session 3 – Arming the Team with the Tools to Achieve Sustainable Change
Session 4 – Burnout, Culture, Teamwork
Session 5 – A Systems Approach to Analyzing Adverse Events
Session 6 – Using a Trigger Tool in Primary Care to Identify Areas for Improvement
Session 7 – Bright Spots from the Field
Ground Rules

- We learn from one another – “All teach, all learn”

- Why reinvent the wheel? - Steal shamelessly

- This is a transparent learning environment

- All ideas/feedback are welcome and encouraged!
Expedition Director

Jennifer Lenoci-Edwards, RN, MPH, CPPS
Patient Safety Director
Institute for Healthcare Improvement
Lead Faculty

Adrienne Allen, MD, MPH
Medical Director of Quality, Safety & Population Health
North Shore Physicians Group
Guest Faculty

Debra Cox, RN, MS, CENP
Nurse Administrator for Connected Care and Global Business Solutions
Mayo Clinic
Objectives:

At the conclusion of this session, participants will be able to:

• Identify three signs of burnout and how this can impact quality of care
• Identify top ambulatory sentinel events related to poor teamwork
• List at least three strategies to impact teamwork: role clarity, hand-offs, and transitions of care
Burnout – Impact to Safety

- Increased turnover
- Decreased patient satisfaction
  - HCAPS/ Press Gainey scores
- Decreased quality of care
  - Increase safety risk when burnout, culture and teamwork are not addressed and optimized
  - Absence of transparency
## Safety Risks in the Ambulatory Setting

<table>
<thead>
<tr>
<th>Category of Errors</th>
<th>Most Common Errors</th>
<th>Specific Areas for Errors</th>
<th>Citation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Knowledge Errors</td>
<td>• Clinical task errors</td>
<td>Studies reported that clinical knowledge errors resulted in patient hospitalization or death, but did not provide detailed information on which errors caused the outcomes</td>
<td>Dovey et al. (2002)\textsuperscript{v}; Pace et al. (2005)\textsuperscript{v}</td>
</tr>
<tr>
<td></td>
<td>• Misdiagnosis</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>• Errors in treatment decisions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Communication Errors</td>
<td>• Information transfer delays</td>
<td>• 23% of PCPs were unaware their patients had been hospitalized 4 weeks postdischarge</td>
<td>Bell et al. (2008)\textsuperscript{v}</td>
</tr>
<tr>
<td></td>
<td>• Barriers to effective communication with patients attributed to low health literacy or low English proficiency</td>
<td>• Health literacy or LEP interventions not applied</td>
<td></td>
</tr>
<tr>
<td>Administrative Errors</td>
<td>• Scheduling errors</td>
<td>• Approx. 50% of patients had pending test results when they left the hospital, and 6% of these were considered potentially actionable</td>
<td>Roy et al. (2005)\textsuperscript{v}</td>
</tr>
<tr>
<td></td>
<td>• Managing patient records errors</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Failure to protect information</td>
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### Safety Risks in the Ambulatory Setting

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<tr>
<td><strong>Medication Errors</strong></td>
<td>• Prescriptions for incorrect drugs</td>
<td>• Cardiovascular 26%</td>
<td>Gurwitz et al. (2003)¹</td>
</tr>
<tr>
<td></td>
<td>• Incorrect dosages</td>
<td>• Antibiotics/anti-infectives 14.7%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Errors most common in aging population on multiple drugs</td>
<td>• Diuretics 13.3%</td>
<td></td>
</tr>
<tr>
<td><strong>Diagnostic Errors</strong></td>
<td>• Missed diagnoses</td>
<td>• Nonopioid analgesics 11.8%</td>
<td>Singh and Weingart (2009)²</td>
</tr>
<tr>
<td></td>
<td>• Delayed diagnoses</td>
<td>• Anticoagulants 7.9%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Incorrect diagnoses</td>
<td>It is not clear which types of diagnostic errors most commonly produced which types of harm, nor which produced the greatest patient harm</td>
<td></td>
</tr>
<tr>
<td><strong>Laboratory Errors</strong></td>
<td>• Switched or lost specimens</td>
<td>• 41% of patients with pending lab results on the day of discharge</td>
<td>Roy et al. (2005)³</td>
</tr>
<tr>
<td></td>
<td>• Delays in communicating test results</td>
<td>• 43% of these were abnormal</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Patient follow-up failures</td>
<td>• 9.4% were potentially actionable</td>
<td></td>
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</tbody>
</table>


Focus of Errors in Ambulatory

- Diagnostic/ imaging
- Provider/ Care Team and patient relationship – adherence is more important focus
- Organizational structure – ambulatory less likely to have infrastructure supporting practice and quality improvement efforts
- Less regulatory and accreditation requirements which provide quality structure
From The Joint Commission’s Sentinel Event Database

- Practicing outside of the scope of an individual’s license and/or certification
- Lack of or inadequate credentialing/privileging of physicians and others
- Lack of or inadequate planning for transitions of care and communication “hand-offs” across and between levels of care
Burnout: Dealing with workplace stress

Fair and Just Culture

1. Human factor/error
2. At-risk or risky behavior
3. Reckless behavior

- Communication and hand-offs – “transitions of care”
- Transparency

“Creating an open, Learning culture. Atmosphere of trust where people are encouraged to be themselves, recognizing that humans are fallible and learn from their mistakes. It is assuming benign intent, giving the benefit of the doubt, and creating an atmosphere of love and respect.” 2016 Nursing Competency – Applying Principles of Fair and Just Culture
What are Transitions of Care (TOC)?

- The movement of patients between health care practitioners, settings and home as their condition and care needs change.
- Effective care transitions must be engineered into the structure of the health care system at each point of exchange – ideally becoming part of the work flow – instead of the current system which relies on the behavior of individuals.
- A set of actions designed to ensure the coordination and continuity of health care as patients transfer between different locations or between different levels of care in the same location.
Miscommunication of all kinds is implicated as one (or more) of the contributing factors in 80% of adverse events.

Substandard hand-offs may result in:

- Delay in treatment
- Inappropriate treatment
- Adverse events
- Omission of care
- Increased costs
- Inefficiency from rework

Problematic hand-off resulted in misinformation to:

- The attending physician
- Consulting physician
- Another resident physician
- Nurse or technician
- Patient or patient's Family
Healthcare Professional Views of Transition From the Hospital

Barriers to Effective Care Transitions

Structural
- Lack of integrated care systems
- Lack of longitudinal responsibility
- Lack of standardized forms and processes
- Incompatible information systems
- Lack of coordination and team-based approaches taught to care providers in school

Procedural
- Ineffective communication
- Failure to recognize cultural, education or language differences
- Processes are not patient centered

Performance/Alignment
- Lack of valid measures for the quality of optimal transitions
- Compensation and performance incentives not aligned with care coordination and transitions
- Payment is for volume of services rather than outcomes

### Ambulatory Practices: AMA’s Principles for High Quality TOC

<table>
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<tr>
<th>Responsibilities</th>
<th>Principles</th>
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<tr>
<td><strong>Assessment</strong> - Conduct baseline assessment prior-to and post-discharge</td>
<td><strong>Person-centered</strong> – focus on patients and caregivers</td>
</tr>
<tr>
<td><strong>Goal Setting</strong> – Document patient’s goals and care decisions</td>
<td><strong>Collaborative</strong> – Take advantage of complementary skill sets of team members</td>
</tr>
<tr>
<td><strong>Supporting Self-Management</strong> – Provide information and facilitate access to resources that can assist the patient/caregivers with safe management of their condition</td>
<td><strong>Structured</strong> – Use clear and carefully planned protocols, forms and processes</td>
</tr>
<tr>
<td><strong>Medication Management</strong> – Communicate with the patient, pharmacy and other members of the care team to promote effective and safe medication use</td>
<td><strong>Iterative</strong> – Recognize the evolving nature of care and make adjustments as appropriate</td>
</tr>
<tr>
<td><strong>Care Coordination</strong> – Synchronize the efforts of all members of the care team</td>
<td><strong>Flexible</strong> – Pursue creative solutions to novel problems based on unique patient needs</td>
</tr>
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Care Coordination and Transition Management

A process that seeks to achieve the optimal cost-effective use of scarce resources by helping individuals obtain health and appropriate social and life support services that meet their unique needs at a given point in time or across lifespan.

• Examples of specific care coordination activities include:
  • Patient advocacy
  • Education and engagement
  • Assessing patient needs and goals
  • Creating a proactive care plan
  • Helping with transitions of care
  • Monitoring and follow-up, including responding to changes in patients’ needs
  • Supporting patients’ self-management goals
  • Linking to community resources
  • Working to align resources with patient and population needs

Burnout: Dealing with workplace stress

Enhancing work environment

- Teamwork – TEAMSTEPP work in clinics
- Communication
- Role clarification and full scope functioning – MA/RN/NP/MD
- RN Role Position Paper
Burnout: Dealing with workplace stress

Skill development to manage stress
- Resiliency for patients AND staff
- Self-efficacy can be learned!
- Positive Job performance = retention
- Nurse residency programs/ orientation
- Interprofessional team focus growing
Burnout, Culture and Teamwork

- What are you doing to combat burnout?
- What roles and processes are you hard–wiring into your practices?
- Who serves as the risk manager for your team?
- How does your teamwork rate?
References:

- Mansur J. Transitions in Care: What are you doing to improve the process? Oak Brook Terrace, IL: Joint Commission Resources. 2013. 1-38
References:

- National Transitions of Care Coalition. Improving transitions of care. 2008 May. 1-44
Questions?
Questions/Discussion

Raise your hand

Use the chat
Expedition Communications

- All sessions are recorded
- Materials are sent one day in advance
- Listserv address for session communications: ambulatorysafetyexp@ls.ihi.org
- To add colleagues, email us at dperes@ihi.org
Next Call: Session 5

Session 5 on November 23.
Thank You!

Please let us know if you have any questions or feedback following today’s Expedition session.

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