CLARITY White Paper

Risk-Quality-Safety Beyond the Traditional Hospital Setting

Part 2: The Foundations of a Successful Ambulatory Safety Program

This is the second in a series of white papers to discuss the needs, challenges, approaches and results of addressing patient safety in ambulatory settings* with an integrated risk-quality-safety (RQS) management strategy.

Characteristics and Challenges to Patient Safety in Ambulatory Settings

In the first white paper, *The Time for Awareness is Now*, we discuss the conditions that have led to the growth of the ambulatory sector and how to confront the various challenges toward patient safety inherent in those settings. We discuss how various factors—from economic, to technological, to legislative—have driven an unprecedented surge in the sector that has only been magnified by the growing complexity of healthcare delivery systems and an accelerated movement towards coordinated care management structures. And, while healthcare providers, risk managers, insurers, legislators and administrators have made some strides in creating safer hospital settings, historically, there has been an inconsistent patchwork of quality and safety efforts directed specifically toward delivery of care in ambulatory settings.

Common Issues in Ambulatory Settings[1]

- Missed or delayed diagnosis
- Delay in proper treatment
- Not providing or recommending preventive services…leading to care/treatment delays
- Medication errors/ADEs
- Hand-offs
  - Ineffective communication
  - Lack of or poor information flow

With this backdrop, how can healthcare providers address risk, quality and safety management in ambulatory settings? As we embark on part two of this series, we will attempt to answer this question and outline the core components of a well-rounded and proactive ambulatory safety program.

**For the purposes of this white paper series, "ambulatory" is defined as care that is delivered in non-hospital settings such as surgical centers, outpatient care centers and office practices. "Ambulatory" and "outpatient" are used interchangeably within this paper.*

Ambulatory Safety Program Basics

A successful ambulatory safety program should first serve to improve awareness of those areas with the greatest risk for harm in ambulatory settings. Following that, a successful program requires systems to create and implement tools and strategies that improve the overall care delivered and address those known areas with the greatest risk for harm. To tie it all together, there must also be coordinated structures in place that streamline communications and enable interventions throughout the entire system of care, ensuring that any processes that are successful in the hospital setting, or other areas, are translated into the ambulatory setting.

Baseline – Professional Liability Claims Review

Before you can effectively change the picture of patient safety in any setting, you must first have a full and accurate understanding of the current practices uniquely contributing to patient safety. By looking closely and holistically at the baseline information (all current and historic data and trends), you are able to identify areas that require specific attention.

To start, you must set a timeframe for establishing baseline performance metrics. Using professional liability claims data, real-time and historic event reporting, and workplace surveys, you can establish the current picture of your patient safety environment and have a useful reference for any measurable improvements that come as a result of your efforts. Often, there is a correlational gap between the claims data and the understanding of the underlying safety issue(s) that may have contributed to those patient hazards. It is important to take a multi-year, in-depth review of all data from claims (five years is recommended) and pinpoint the biggest risk factors that lead to the patient safety issues in this setting.

This review should also include cross-comparisons with other information systems in your organization. Ask yourself:

- Did you already have an intuitive sense of any glaring patient safety issues?
- Did your data/discoveries surprise you?
- Have you clearly identified your critical areas of risk by:
    - Greatest patient harm/impact
    - Greatest cost of medical malpractice claims
    - Greatest frequency of patient safety type/category

- Did issues such as communication breakdowns allow for known risk factors to go unnoticed or not be appropriately addressed?
- Are there contributing factors that clearly precipitated a safety issue? If so, do you have processes in place to mitigate?

Baseline - Practice Patterns Self-Assessment (PPSA)

A Practice Patterns Self-Assessment (PPSA) is a thorough survey of practice settings that will help you gauge the climate of safety at your organization and identify where there might be patient safety issues. The survey allows an organization to gather information from staff and clinical providers and understand the practice patterns unique to its care delivery setting. While surveys will vary greatly based on the unique characteristics of a given organization and setting, the elements of the survey should allow you to identify areas such as:

- Do you understand and have a process for patient follow-up and compliance?
- Do you have, and comply with, infection prevention/procedural/testing practices?
- How well have you established communication channels?
    - Physician coverage
    - Referral tracking
    - Appointment compliance
    - Test results
- Do you have a process for tracking and follow-up regarding complaints and satisfaction from patients?

Once you have a picture of known risk factors and you have pinpointed the gaps in communication, you can start to address them; with a PPSA, you gain a better understanding of your practice patterns and how to prioritize patient safety concerns.

Building Awareness and Creating Processes that Work – The Early Warning System

Historically, ambulatory healthcare providers have not participated in event reporting and review. However, there is great interest in learning more about this aspect of patient safety management. As you come to understand the two areas of your baseline data (your historical claims and practice patterns), awareness of your own patient safety practices begin to formulate. Part of this awareness allows you to uncover the gaps in properly managing patient safety in ambulatory settings. Often times providers identify that:

- The time and pace of the ambulatory setting is increasingly difficult to manage
- Resources are limited and areas such as quality and safety are not clearly defined or well-appointed for dealing with ambulatory events specifically
- Reporting processes for early identification are often complex or non-existent

Beyond establishing your baseline information and building the initial awareness, there is a third component that puts the risk-quality-safety (RQS) process into real-time motion – the need for a system-wide process to capture patient safety information from all aspects of the healthcare system. This process is important in establishing an Early Warning System for potential and real harm that may come to patients, and it generally takes the form of an event reporting system.

Many large organizations with both traditional and non-traditional care settings already employ an event reporting solution. However, for a solution to be effective and used by staff in the ambulatory area, it must be simple and include setting-specific event reporting templates. Ideally, the ambulatory tool should include mechanisms for investigatory work and follow-up to help keep awareness high and provide actionable information. Keep in mind that as systems are built, different resources and skill-sets may be required, so you might need to consider outside resources/experts who have experience in building, managing and analyzing these RQS systems.

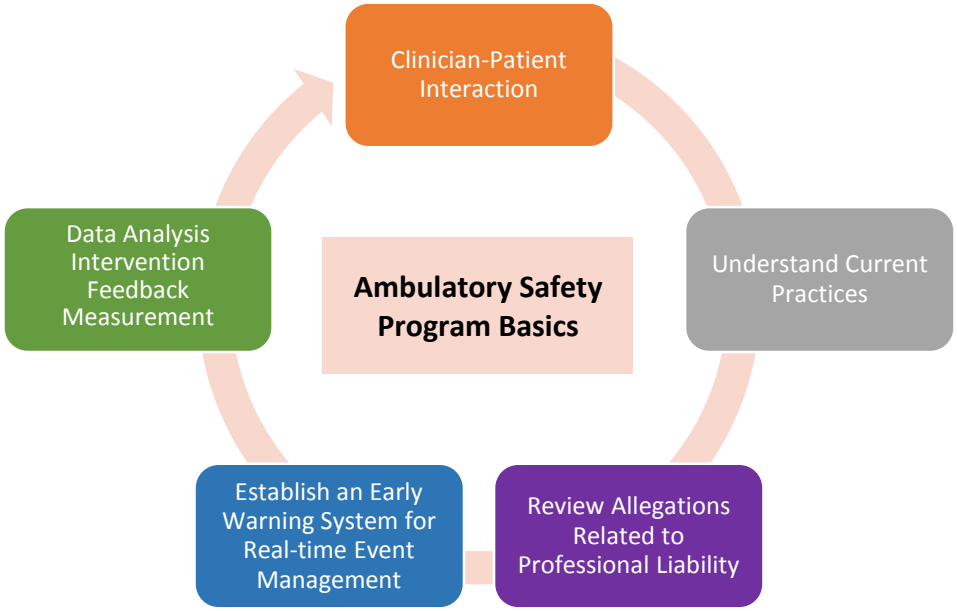
Even with the proper tools and strategies in place, your ambulatory safety program will not be effective unless you have a strong communication plan established from the very beginning. Having the right team members active and engaged reinforces a culture of reporting and constant awareness through timely feedback, education and thorough follow-through. The following are a few strategies used by our ambulatory providers to improve their patient safety communication:

- Be creative! Offer incentives for reporting and participating in problem solutions
- Actively seek out feedback from all sources
- Conduct safety contests and offer rewards for best practice identification

- Build communication right into your Early Warning System
- Identify key stakeholders responsible for certain safety areas
- Identify projects and initiatives that are currently underway
- Offer Just-In-Time education at the same time events are reported

Measure of Success

Once you have established your current picture, gained buy-in for a reporting culture, fostered learning from data analyses and prepared workable interventions, it is important that you test your successes. But before you roll out interventions across the entire organization, start by implementing interventions on small test samples in order to concretely evaluate them. An ongoing evaluation process, including data reporting and communication systems and tools, is also important to help you assess the long-term successes of your interventions. Ultimately, lessons learned from the sample testing and evaluation process will lead to the development of a collaborative model that can be applied to new services contemplated in the setting or practice.



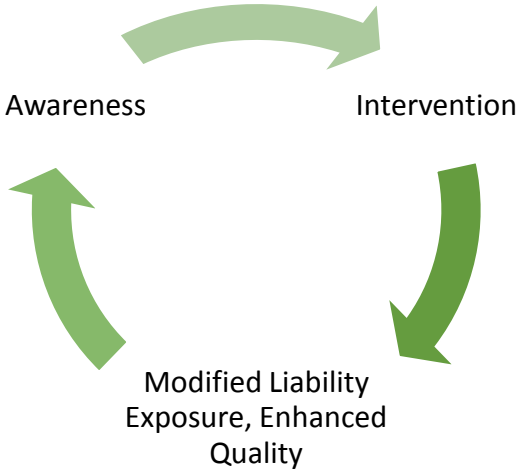
Gaining Protection and Creating a Safe Learning Lab

In most states, protection from discovery under Medical Studies or Quality Improvement Acts is limited to hospital organizations. The federal Patient Safety and Quality Improvement Act (PSQIA), however, offers protection to a wide range of healthcare providers and includes both protections from discovery and confidentiality/disclosure. As such, contracting with a Patient Safety Organization (PSO) expressly defined by

the PSQIA statute, provides a way of creating an umbrella, or safe environment that allows organizations to dig deep into matters of patient safety and learn about the underlying risks and causes of harm in the care delivery process. The PSO program is becoming increasingly important and accepted in ambulatory settings as a vehicle to advance quality, safety and patient outcomes in a safe environment protected from potential discovery.

Closing the Spiral of Positive Change

As we discussed in part one of this series, everyone in the ambulatory setting – from the office manager to individual physicians and health professionals – plays a critical role in improving care delivery. All staff members must be involved in the education process in order to achieve a shift in thinking that can lead to real change and prevention of harm throughout integrated care systems. And since the process of culture change is one that requires vigilance and knowledge in the form of data to create awareness around risk, quality and safety issues, a well-rounded ambulatory safety initiative is crucial in gaining the insights necessary to create a plan of action.



The third and final white paper will address translating the findings of an aggressive ambulatory safety initiative into sustainable interventions that can permanently affect positive change throughout an organization. We will provide examples of specific interventions stemming from our own client ambulatory safety initiatives, backed by case studies demonstrating actual results based on our findings.

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[1]Claims Analysis Findings, Clarity Group, Inc., Ambulatory Safety Initiative Pilot Program

A Word about Clarity's Ambulatory Safety Initiative

Reflecting on our years of education, insights and interventions in the ambulatory safety arena, Clarity developed a suite of products and services to address the climate challenges and process needs of a successful ambulatory safety program. Clarity ASI (Ambulatory Safety Initiative) ties data together from the following sources to address patient safety across all ambulatory settings:

Professional Liability Claims Review and Analysis

An in-depth, professional liability claims review and analysis will give you the insights you need to assess the impact of ambulatory safety claims on your organization and help you identify where your resources are needed the most.

Risk, Quality, Safety Office Practice Survey

A detailed RQS Office Practice Survey helps gauge the climate of safety in your ambulatory settings and identify areas where there might be issues. The survey allows an organization to gather information straight from its providers and understand the practice patterns of each setting. By knowing what is currently happening, the organization can identify and implement necessary changes.

The Ambulatory Safety Module of Clarity's Healthcare *SafetyZone®* Portal

Clarity's **Healthcare *SafetyZone®* Portal** is a user-friendly, state-of-the-art software product for capturing and managing the information that is most important to you. The **Ambulatory Safety Module** (ASM) within the Portal allows you to customize and specify a set of reporting templates that are applicable to you and your ambulatory needs. It also allows you to assign tasks, manage workflow and conduct investigations in a way that is seamlessly communicated throughout the organization. The ASM is used to gain insight into the quality and safety of care in the ambulatory setting and identify key touch points where patients may be at risk for harm or incorrect care. By better understanding the risks and errors associated with the ambulatory setting, you can develop strategies that improve clinical outcomes, resource utilization and financial reimbursement throughout the organization as a whole.

For more information on Clarity Group, Inc. and Clarity ASI, please visit www.claritygrp.com