THE “NEW” COMPLEX PATIENT
The Shifting Locus of Care and Cost

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Section Six

Care Outside the Hospital: Maintaining Quality and Safety

Ronni Solomon
Executive Vice president and General Counsel
ECRI Institute
Synopsis

- Great Britain Hospital
- Avalon Hospital
- Avalon Transplant Center
- Excalibur Outpatient Center
Root Causes

- Communication
- Care Planning/Coordination
- Discharge Planning
- Documentation
- Human-Computer Interface
- Leadership/Culture
- Equipment Design
- Training
Patient Safety Beyond the Hospital

- 35 million hospital visits
- 1 billion physician offices in the US each year
- Spending on outpatient care is fastest growing segment of healthcare spending
- Only 10% of patient safety studies have been performed in outpatient settings
- Chronic patients take more medications including higher risk medications.

Safety Issues Differ

**Inpatient**
- Treatment errors
- Near-constant observation
- Safety infrastructure
- Highly regulated
- Structured information

**Outpatient**
- Diagnostic Errors
- Self-management
- Little safety infrastructure
- Less regulated
- Dispersed information
• Nearly 20% of patients experience adverse events within 3 weeks of discharge (Nearly three-quarters of which could have been prevented or ameliorated).
• Adverse drug events are the most common post–discharge complication
• Nearly 40% of patients are discharged with test results pending
• Nearly 40% are discharged with a plan to complete the diagnostic workup as an outpatient

ECRI Institute Safety Programs

- Adverse event, near miss, hazard reporting programs
- Proactive Assessments
- Review of root case analyses
- Accident investigation
- Public and private sector safety and risk management projects
  - Partnership for Health IT Patient Safety
- ECRI Institute PSO
Top Ten Patient Safety Concerns

ECRI Institute’s Top 10 Patient Safety Concerns for 2014*

1. Data integrity failures with health information technology systems**

2. Poor care coordination with patient’s next level of care

3. Test results reporting errors

4. Drug shortages

5. Failure to adequately manage behavioral health patients in acute care settings

6. Mislabelled specimens

7. Retained devices and unretrieved fragments**

8. Patient falls while toileting

9. Inadequate monitoring for respiratory depression in patients taking opioids

10. Inadequate reprocessing of endoscopes and surgical instruments**

Top 10 Patient Safety Concerns for Healthcare Organizations

Poor Care Coordination with Patient’s Next Level of Care

Care coordination is a “shared responsibility” of all providers involved in a patient’s care, says Lorraine Possanza, D.P.M., J.D., M.B.E., patient safety, risk, and quality analyst at ECRI Institute. “It can’t just be up to the patients,” she says. However, events reported to ECRI Institute ISO reveal gaps in communication about patients’ care—between hospital and providers, among providers, and between long-term care settings and hospitals or other providers. For example, in one event, an infant’s discharge summary, which contained important follow-up care information, was not provided to the patient’s primary care physician:

An infant who died from sudden infant death syndrome had previously been seen in the hospital for a life-threatening event. Because of abnormal findings on the patient’s CT [computed tomography] scan, the patient’s discharge summary indicated the patient should have an MRI [magnetic resonance imaging] exam. The discharge summary was not sent to the patient’s primary physician. The patient did not undergo the MRI study.

While a best practice is for hospitals to send a patient’s discharge information to all the patient’s providers, staff can be overwhelmed trying to identify those providers. “It’s not only the hospital’s responsibility,” says Possanza, who previously had a podiatry practice and has experience with care coordination challenges. “It’s also on me as the patient’s provider to communicate with the patient’s other providers,” she says, recalling that in addition to communicating with patients’ providers as needed, she used to “touch base” with her patients’ other providers at least once a year “so they know I’ve been involved in the patient’s care.”

Electronic health records (EHRs) can facilitate communication about a patient’s care among providers, but organizations must establish procedures that address accessing, reviewing, and acting on the findings in those records. For example, what happens if a provider who is viewing a patient’s record discovers that results of tests ordered by another provider have not been acted upon? EHRs could become a barrier “if physicians are second-guessing one another,” says Possanza. Organizations might find it helpful to develop a policy specifying procedures for a provider who finds an abnormal laboratory or pathology result with no indication that the abnormal result was acted upon.
Deep Dives into Adverse Event Data

- Medication errors, health IT, lab testing, care coordination (soon)
- Analyses of adverse events, near misses
- Risk reduction recommendations, tools
- For lab testing:
  - majority of events occurred in preanalytic phase
  - remaining occurred during the postanalytic phase
Medication Safety

- ADEs spur 4.5 million visits (Sarkar et al, Health Serv Res. 2011)
- Over half of patients have a medication discrepancy at the time of admission (Cornish, Arch Int Med 2005)
- A comparison of medication records for patients older than 65 years discharged from hospitals to subacute care revealed that 86.2% of the records had at least one medication discrepancy. (Fitzgibbon M, Lorenz R, Lach H. J Gerontol Nurs)
Medical Office Safety

- Work pressure and pace
- Appointment reminders
- Documents how well patients follow treatment plans
- Follows up with patients who need monitoring
- Follows up when reports from an outside provider are not received

- Process to educate patients taking more than 7 medications
- Following up with patients who do not show up for an appointment
- Follow-up process for patients with high-risk behavioral problems
- Staff use preprinted checklists for procedures performed in the office

**AHRQ’s Medical Office Survey on Patient Safety Culture**

**ECRI Institute Insight Physician Practice Survey**
Ambulatory surgery centers can be risky for older patients

By Sabriya Rice | September 12, 2014

In the wake of the surgery-related death of comedian Joan Rivers, patient-safety leaders and some physicians are calling on outpatient surgery centers to carefully select elderly patients eligible for surgery and encouraging patients to question the qualifications of physicians performing the procedures.

Surgery carries risk for everyone, but older adults are more likely to have multiple health conditions that can affect how their body responds to even minor surgical procedures. If something goes wrong, they’re likely to deteriorate more rapidly, so having access to emergency care is essential, geriatricians say. They also warn that not all ambulatory surgery centers are staffed to handle a crisis, and the patient’s condition can worsen as they await transfer to a hospital, safety leaders warn. “If something goes slightly wrong, it’s much more likely to turn into a big problem in an older person than a younger person,” said Dr. Jonathan Flacker, chief of geriatrics and gerontology at Emory University and a spokesman for the American Geriatrics Society. Older patients often have less physiological reserve, and even relatively healthy older adults may have more difficulty coping with the...
SNFs, Assisted Living

- Falls, Falls, Falls
- Transitions of care

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Bracing for the Falls of an Aging Nation
By KATIE HAFNER

It took a fall to destroy Eleanor Hammer’s confidence for getting around without a walker. She was unhurt, but the experience was sobering.

As Americans live longer, fall-related injuries and deaths are rising, and homes for the elderly are tackling the problem in ways large and small — even by changing the color of their carpeting and toilet seats.
Safety Communication for Clinicians

Get Safe: Ensuring Care Coordination of the Medically Complex Patient

- Get Safe! Checklists
- Advisories
- Toolkits
- Webinars
- On-line learning, CME

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Patients as Vigilant Partners in Quality

- Increasingly, hospital professionals have options for reporting safety incidents.
- Patients can recognize errors and injuries that may not be apparent to providers.
- Few systems are designed to obtain safety reports directly from patients or caregivers.
- The optimal approaches for collecting patient and caregiver feedback on safety are still being defined.
Consumer Reporting: A Free for All
Health Care Safety Hotline

- AHRQ Project

- Objective: Design and pilot a standardized approach to collecting patient, family, and caregiver reports about safety-related issues

- Implementation and evaluation phase
Proposal for The Next Decade

1. Collect basic data on care-related harm in the ambulatory setting
2. Identify an early achievable goal
3. Engage patient and their families on the safety improvement team
4. Link the agenda to related high profile inpatient initiatives
5. Conduct demonstration projects

Wynia, Classen. JAMA. December 14, 2011
Thank you