Pilot to Improve Patient Safety Reporting in Primary Care Practices

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BACKGROUND / INTRODUCTION

- Improving patient experience of the health care system, including improving patient safety, has been a goal since the release of To Err is Human in 1999.
- Much work has been done at the national, state, and local levels to document and address patient safety events that occur in hospital settings.
- Outpatient encounters outnumber hospital encounters by 300:1. More than half of those visits are to Primary Care Practices.
- Patient Safety Events in Primary Care Practices occur with frequency, however, practices under-report these events.
- Lehigh Valley Physicians Group (LVPG) is a multispecialty physicians group with over 245 outpatient practices, including 50 Primary Care Practices, owned and operated as part of Lehigh Valley Health Network in Eastern Pennsylvania (LVHN).

PROBLEM STATEMENTS

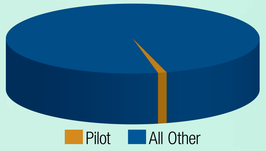
- How do we increase patient safety reporting in our primary care practices?
- How do we promote Safety Culture in the outpatient practices and in the physicians group?
- How do we surface system issues for the physician's group?

METHODS

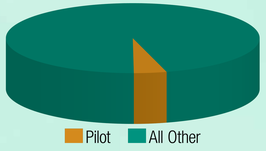
- Three Family Medicine practices volunteered for this pilot.
- Practices would use the existing electronic safety event reporting system, RL6. Note that, for regulatory compliance RL6, has 23 different report categories to choose from.
- Network Patient Safety Officers and the Medical Director for Quality and Safety educated practices on patient safety, common ambulatory safety events, and in using the event reporting system.

QUANTITATIVE RESULTS

PRACTICES



REPORT VOLUME



- Relative to other practices in LVPG, pilot practices were more likely to report events
- The following Event Types were reported most frequently from Pilot practices
  - Medication errors
  - Patient Feedback/ Patient Complaint
  - HIPPA/Privacy violations
  - Delayed diagnosis

QUALITATIVE RESULTS

REPORTING
- Variability in the time to complete a report based on experience
- Variability of those responsible for reporting
- Variability in event resolution work flow

CHALLENGES
- Time and opportunity to complete report
- Uncertainty of what constitutes a patient safety event
- Limited opportunity to incorporate standardized event reviews
- Staff turnover and Practice transitions

BENEFITS
- Timely identification of events and trends
- Ability to react to trends and improve practice operations
- Identification of quality events reported via Patient Feedback
- Identification of "Good catches"

LESSONS LEARNED

- Educating practices on reporting did lead to an increase in Event Reports. However, many events still went unreported.
- Time is the greatest barrier to the safety event reporting process:
  - Time available to providers and staff during busy office schedules.
  - Time needed to complete a detailed report.
  - Time to meet as a practice to review events.
- Event Reports were useful in identifying safety risks and lead to process changes.

FUTURE DIRECTIONS

- A specific outpatient reporting form has been developed for the RL6 reporting system. This shortened form is expected to streamline the reporting process. After testing it will be disseminated to all outpatient practices.
- Opportunities to review and resolve reports need to be built in to practice operations to support the development of a safety culture.

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