

Breakout Group Five

Practical, Real World Application of Patient Safety Initiatives Practical,
Real World Patient Safety Applications

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BACKGROUND

The literature in medical journals, industry periodicals, the media and publically reported incidents presents strong opportunity for clinical improvement. This ranges from assuring 100% compliance with hand washing to usage of clinical guidelines and evidence based protocols to assure medical professionals provide consistent care designed to improve outcomes. Payers have moved on to *never events* where payment will not be made for errors in technique or avoidable outcomes. The usage of objective measurement, incorporation of continuous improvement system processes, team building and systems thinking has resulted in substantial improvement. We are making changes, but slowly. Where else and what else can we do as physicians to accelerate change and provide safer medical care.

Current Observations:

As physicians, we are bombarded with new requirements, threats of financial penalties, suggestions for changes in how we provide care, metrics for identifying our strengths and our weaknesses. What underlies these actions and how can we as a profession make sustainable improvements to accomplish what we all wish. The recognition that our current way to providing health care is siloed, provided in less than an optimal 'team based/patient centric process' results in unintended results that cause patient-safety issues. We are running hard, but seeking to make unsustainable changes on a one by one, issue-by-issue basis.

Current Organizations Providing Help:

The list is long and in many instances, redundant. 'Redundant' is the good news, hearing 'things' once won't lead to change; hearing things seven times improves this. But the average time for adoption of new evidence based medicine is 17 years. This is completely unacceptable.

So who and what is leading change? For Colorado, a cursory view includes:

COPIC: medical management tools, patient focus, communication and system improvement

CCGC: ambulatory guidelines, IPIP, data registry adoption, work flow improvement

CFMC: QIO measurement and improvement of NH, HH, Hospital care with documented improvement from 9th to 7th in the country for Medicare; adoption of EMRs, work flow improvements and reporting of clinical data by physicians; implementation of Dr Eric Coleman's Care Transition to help patients and their providers reduce unnecessary readmissions by 50%, the 100k Lives and 5 Million Lives IHI efforts to improve quality and make health care safer: funded by The Colorado Trust in Colorado patient safety training for residents at three Denver area hospitals: funded by The Colorado Health Foundation efforts funded by the state of Colorado for Get With the Guidelines to improve compliance with cardiac care.

CBGH: Bridges to Excellence, Leap Frog reporting on patient safety compliance, purchasing of Value Driven Health Care

CIVHC: leading to adoption of the IHI Triple Aim, Accountable Care Organizations, and a financial as well as operational restructuring of how health care is delivered in a non-siloed environment for Medicaid and coordinated with private payers.

Colorado Hospitals:

Individually, corporately and by their association, Colorado Managed Care organizations, state mandated clinical reporting, individual reporting requirements by payers including HEDIS, never events, medical errors, system improvements.

Medicaid, the state Health Department, licensing boards, specialty societies and component medical societies are all pushing patient safety and improvement activities.

Breakout Instructions:

And given the above plus, no doubt, more: What else should/can be done?

So the purpose of our discussion is to explore what else should be done to measure and improve patient safety. These efforts are not just physician, they are inclusive of patients, family, other health professionals, office staff, pharmacists, usage of EMRs, usage of HIE, care coordination by patient focused coaches, development of accountable care communities, activation of patients, development of medical delivery communities, strengthening your and your office staff's relationship with patients and their other care givers to create a whole patient centric approach, educating patients to help assure what we as clinicians wish to do, we do.

This is a discussion of CHANGE, of implementing system changes to cause improved patient care. A discussion of the Care transitions 14 state (including Colorado) project will be presented by Dr. Jane Brock. This is an effort to improve care, reduce readmissions and to identify what we miss before patient safety is compromised. And it is a discussion not of blame, but of system redesign and innovation that keeps patients healthier, that focuses on better patient management through their continuum of care, and not just by your specific clinical practice.

A second discussion from the patient perspective concerning opportunities for patient efforts to help their physician more efficiently provide care, will be led by Arja P. Adair Jr.

Come join us, share what you are doing in your office of facility based practice (hospital, nh, hh, office) and learn what we are using at CFMC and other organizations to improve patient focused care while improving patient safety.