Tools for Building Quality and Safety in Outpatient Care

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Objectives

1. Use the Medical Office Survey (MOS) to identify areas of culture in need of improvement to support a Patient Centered Medical Home (PCMH)
2. Describe examples of how results from the MOS have guided system redesign and implementation of teamwork to support PCMH at the University of Nebraska Medical Center.
3. Identify the key principles of teamwork taught in the TeamSTEPPS Curriculum.

Purpose of a Medical Home

The purpose of the medical home is to enhance the coordination of care within the interprofessional team, improve the quality of the patient/physician relationship, and decrease overall health care costs.

Rosenthal, T. C. (2008). The medical home: Growing evidence to support a new approach to primary care. *Journal of the American Board of Family Medicine : JABFM*, *21*(5), 427-440

NCQA Certification Standard

Enhance Access/Continuity

- Patients have access to culturally/linguistically appropriate routine/urgent care & clinical advice during & after office hours
- The practice provides electronic access
- Patients may select a clinician
- **The focus is on team-based care with trained staff**

http://www.ncqa.org/

Geriatrics & PCMH: a Natural Partnership

Geriatrics: team-based, whole person care for older adults.

1. Potential increased reimbursements with demonstration projects, healthcare and insurance reform.
2. Competencies/curricular redesign for residents, fellows, medical students & other HCP students

Opportunities

- Improve patient care: transitions, access, education, self-management, avoid unnecessary hospitalizations, improve health and decrease overall healthcare costs.
- Imbed Geriatrics QI into standard care.
- Improve patient and staff satisfaction.
- Reduce burnout (and encourage trainees to explore primary care as desirable option).

MEDICAL OFFICE SURVEY ON PATIENT SAFETY CULTURE (MOS)

- Developed by AHRQ to provide outpatient offices with a tool to determine whether the office culture:
  - Emphasizes patient safety
  - Facilitates teamwork and discussion about mistakes
  - Engages in continuous learning & improvement
- Pilot tested with 10,567 staff , 470 medical offices. Provides comparative database

http://www.ahrq.gov/qual/patientsafetyculture/mosurvindex.htm

Common Elements between NCQA PCMH and MOS

1. Access/communication
2. Patient tracking/registries
3. Care management
4. Patient self management support
5. Test tracking
6. Electronic prescribing & communication
7. Referral tracking
8. Performance reporting & improvement

Definition of Safety Culture

- **Enduring, shared, LEARNED[1] beliefs and behaviors that reflect an organization's willingness to learn from errors[2]**
- **Beliefs consistent with goals of PCMH[3]**
  - We use teamwork to coordinate care for patients
  - We communicate effectively
  - We close the loop…test results, preventive care, monitoring
  - We use standard processes to work efficiently and share information with patients, families, other providers
  - We report and learn from mistakes

1. Schein, E. *Organizational Culture and Leadership*. 4th ed. San Francisco, CA: John Wiley & Sons; 2010.
2. Wiegmann. A synthesis of safety culture and safety climate research; 2002. http://www.humanfactors.uiuc.edu/Reports&PapersPDFs/TechReport/02-03.pdf
3. Rosenthal, 2008; Bodenheimer, Wagner, & Grumbach, 2002; American Academy of Family Practice http://www.aafp.org/online/en/home/membership/initiatives/pcmh.html

MOS – 52 Items in 12 Dimensions

1. Communication about error
2. Communication Openness
3. Information Exchange with Other Settings
4. Office Processes and Standardization
5. Organizational Learning
6. Overall Perceptions of Patient Safety and Quality
7. Owner/Managing Partner/Leadership Support for Patient Safety
8. Patient Care Tracking/Followup
9. Patient Safety and Quality Issues
10. Staff Training
11. Teamwork
12. Work Pressure & Pace

"…in many organizations, values reflect *desired* behavior but are not reflected in *observed* behavior."

Schein, E.H. Organizational Leadership and Culture 4th ed. San Francisco: John Wiley & Sons; 2010, p.24, 27.

http://search.dilbert.com/search?w=values&view=list&filter=type%3Acomic&x=44&y=19

The MOS (Cont.)

- **Two overall rating questions**
  - Health care quality (effective, patient-centered, timely, efficient, equitable)
  - Patient safety

- **Ten items to assess TeamSTEPPS at Baseline**

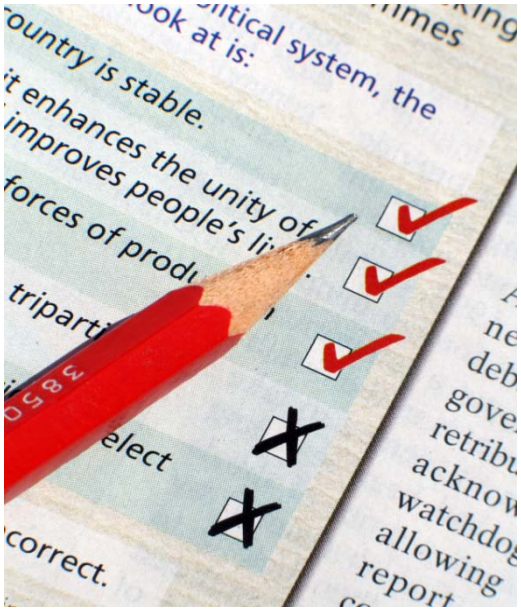
  (Modification of the MOS by UNMC to assess impact of TeamSTEPPS program on culture)

  - Team Training experience
  - Knowledge of TeamSTEPPS Tools (alpha=0.71)
  - Adoption of Team Behaviors (alpha=0.79)

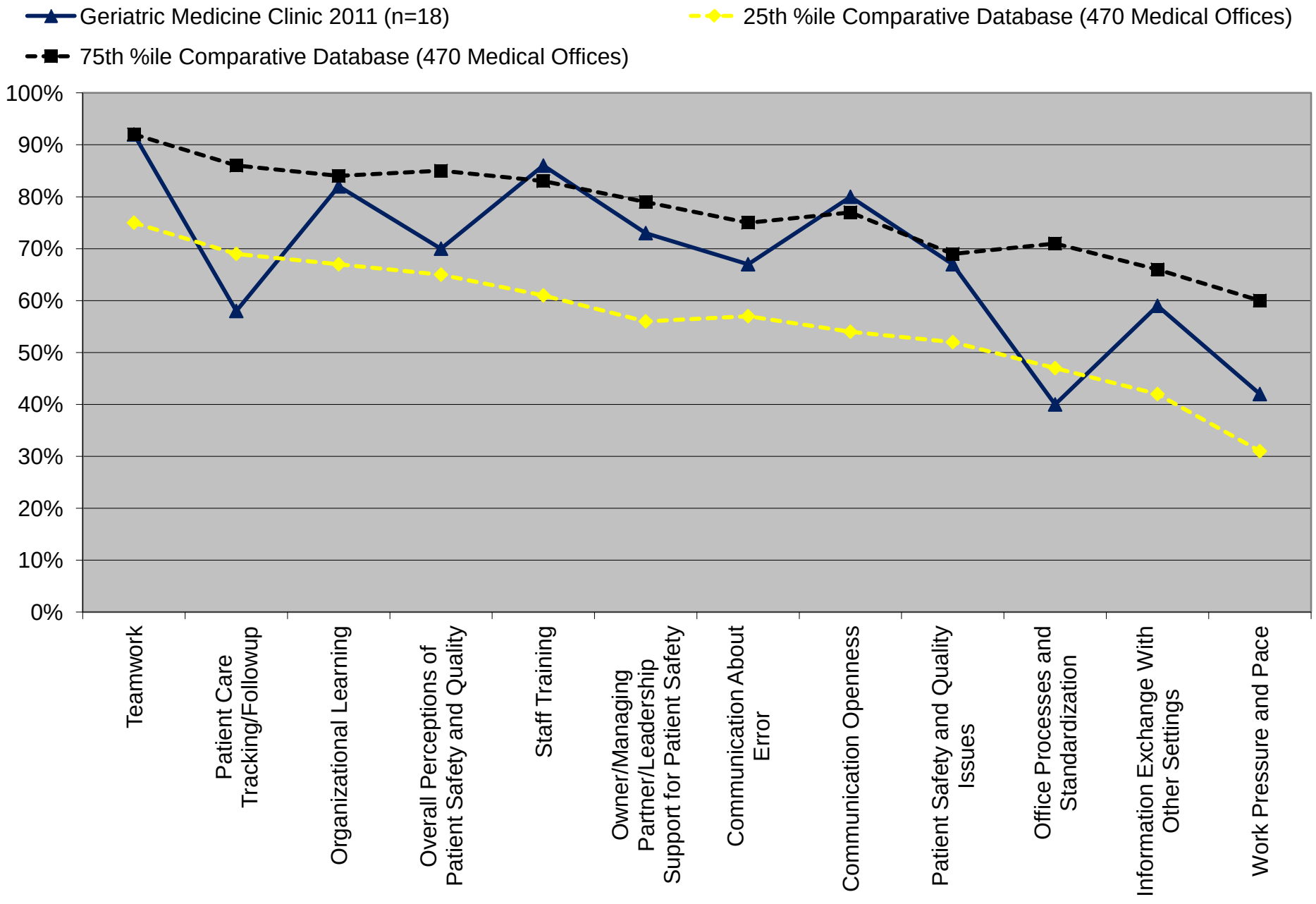
MOS Methodology

- Feb. – March 2011 Baseline assessment
- Personalized paper surveys using Dillman 4-contact method
- Geriatrics Clinic Surveyed (n=25)
- Response Rate:

  18/25 = (72%)

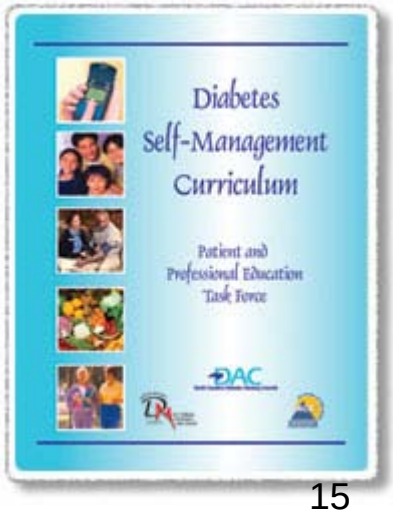


Medical Office Survey on Patient Safety Culture Composite Positive Responses Comparison To National Database



Implementing Key Elements of Medical Home Require Teamwork

1. Sustained relationships
2. Manage complexity of chronic conditions
3. Focus on patient/caregiver self-management
4. Maintain complete record of care



TeamSTEPPS

Team

Strategies & Tools to Enhance Performance & Patient Safety

"Initiative based on evidence derived from team performance…leveraging more than 25 years of research in military, aviation, nuclear power, business and industry…to acquire team competencies"

http://teamstepps.ahrq.gov/

Outcomes of Team Competencies

Knowledge

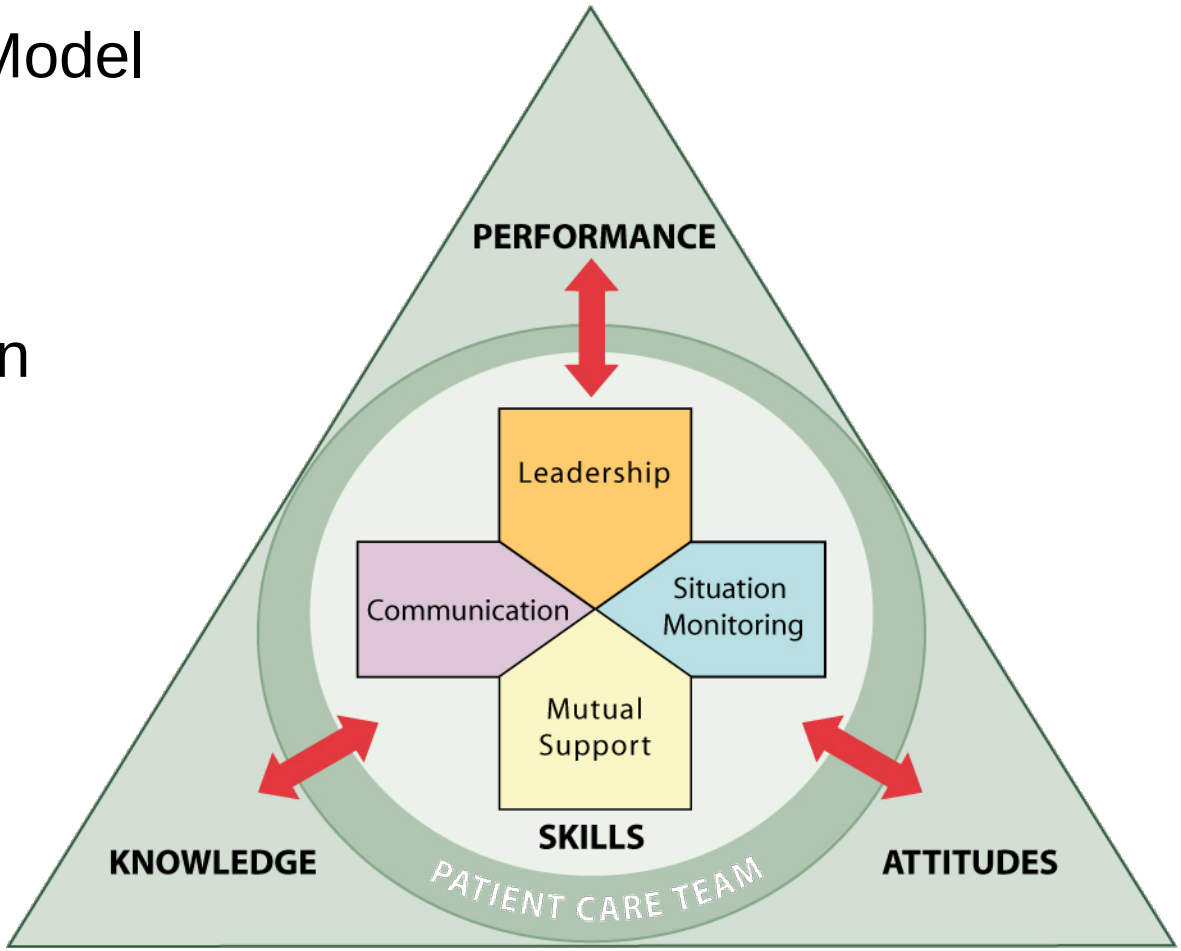
1. Shared Mental Model

Attitudes

1. Mutual Trust
2. Team Orientation

Performance

1. Adaptability
2. Accuracy
3. Productivity
4. Efficiency
5. Safety



http://teamstepps.ahrq.gov/

Fundamentals Course April 30, 2011

Module 1—Introduction

Module 2—Team Structure

Module 3—Leadership

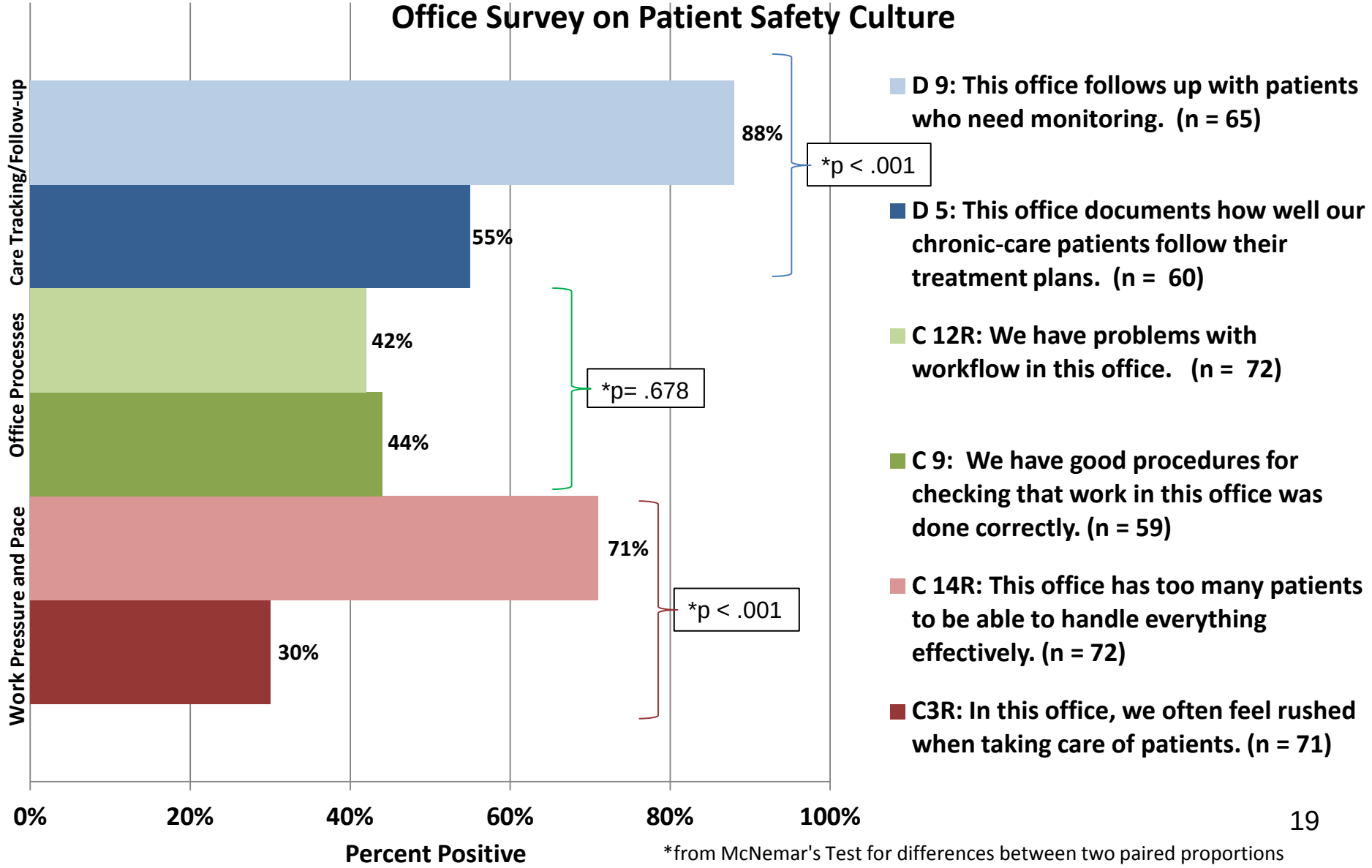
Module 4—Situation Monitoring

Module 5—Mutual Support

Module 6—Communication

Module 7—Summary—Pulling It All Together

Comparing Beliefs and Behaviors Within Specific Dimensions of the Medical Office Survey on Patient Safety Culture



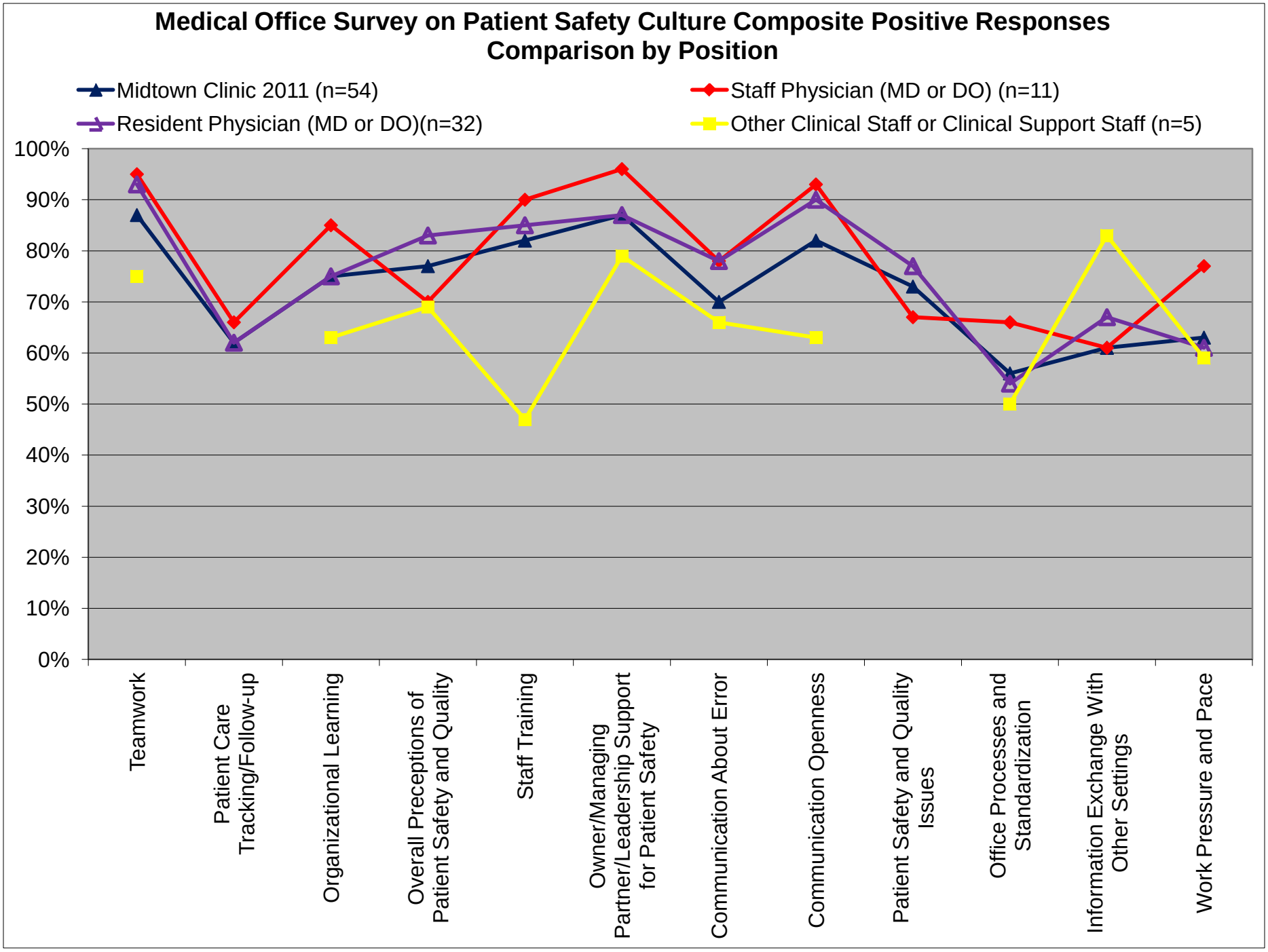
*from McNemar's Test for differences between two paired proportions

TeamSTEPPS Baseline: Geriatrics (n varies)

No formal team training experience	29%
Some experience in team skills; not TeamSTEPPS	35%
Completed some training in TeamSTEPPS	35%
Completed all TeamSTEPPS modules	0%
Correctly defined Brief	0%
Correctly defined SBAR	71%
Correctly defined CUS	6%
Correctly defined STEP	0%
Use SBAR within clinic Most of time/Always	0%
Use CUS within clinic Most of time/Always	0%
Use SBAR or I PASS the BATON to communicate with other organizations Most of time/Always	0%
Use huddle to adjust plans Most of time/Always	29%
Use debrief to discuss improvements Most of time/Always	29%

Small group exercise

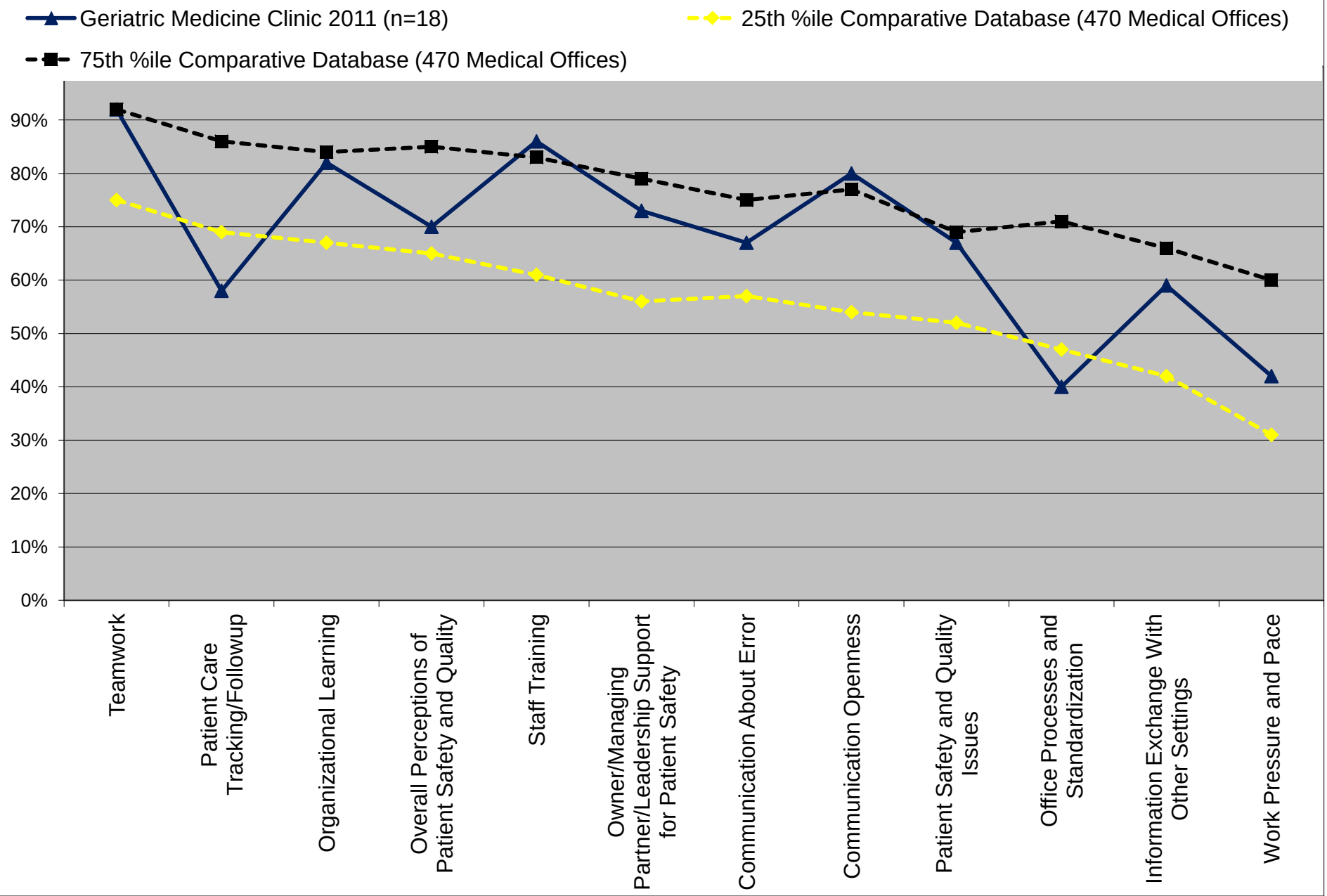
- Break into 4-5 groups
- Assume a role during the discussion:
  - Attending (2), resident/fellow (4), APRN (2), medical assistant (2), clinic nurse (2), receptionist/scheduler (2).
- Opinions vary, example


Medical Office Survey on Patient Safety Culture Composite Positive Responses
Comparison by Position
Midtown Clinic 2011 (n=54)
Staff Physician (MD or DO) (n=11)
Resident Physician (MD or DO)(n=32)
Other Clinical Staff or Clinical Support Staff (n=5)
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Teamwork
Patient Care Tracking/Follow-up
Organizational Learning
Overall Preceptions of Patient Safety and Quality
Staff Training
Owner/Managing Partner/Leadership Support for Patient Safety
Communication About Error
Communication Openness
Patient Safety and Quality Issues
Office Processes and Standardization
Information Exchange With Other Settings
Work Pressure and Pace

Geriatrics Clinic

How the MOS identified problems and set us on a course for improvement using newly enhanced team skills

Medical Office Survey on Patient Safety Culture Composite Positive Responses Comparison To National Database



Team STEPPS Team Training

- Gave us the tools for improvement
- Provided a common language and expectations
- Made safety, quality and satisfaction (for patients and staff) a common goal

Change Team

Who: Social Work, RN, NP, Front Desk, MD, Admin Support

How: weekly, now 2-3x/month meetings

What: address issues identified by the MOS; review what worked (or not); continue the process

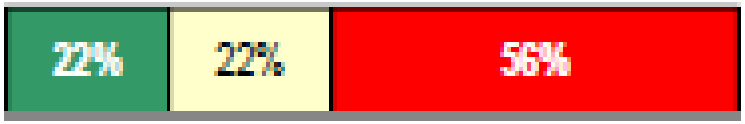
Scale %(+) = 0-2x past 12 mos.; %(N) = Monthly, Sev Xs/yr; %(-)= dly/wkly

Geriatrics Clinic (n=18)

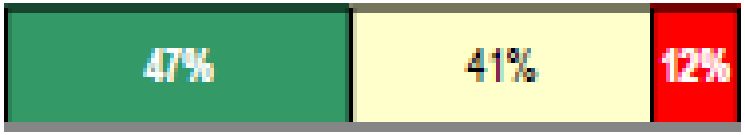
Work Pressure and Pace

12. Work Pressure and Pace

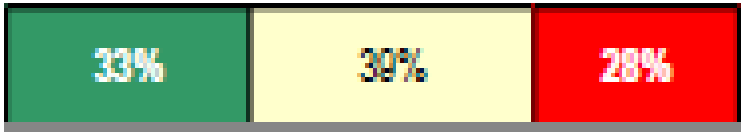
1. In this office, we often feel rushed when taking care of patients. (C3R)



2. We have too many patients for the number of providers in this office. (C6R)



3. We have enough staff to handle our patient load. (C11)



4. This office has too many patients to be able to handle everything effectively. (C14R)

How do we work with our patients more effectively and efficiently and feel less stressed in clinic?

Implement: briefs, huddles, debriefs, situation monitoring, task assistance

1. Briefs: we know who you (the patient) are and why you are here; we know where schedule will be hectic (anticipate task assistance).
2. Huddles: when things aren't going well, fix it immediately (need for huddles reduced with situation monitoring and offers of task assistance)
3. Debriefs: what worked, what didn't, what are anticipated patient follow up needs

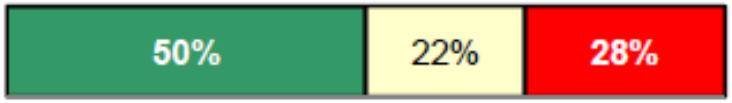
Scale = Strongly Disagree – Strongly Agree

Geriatrics Clinic (n=18)

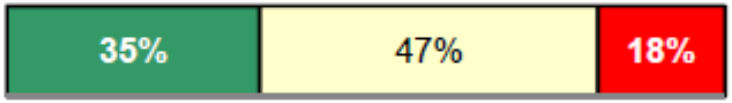
Office Processes and Standardization

10. Office Processes and Standardization

1. This office is more disorganized than it should be. (C8R)



2. We have good procedures for checking that work in this office was done correctly. (C9)



3. We have problems with workflow in this office. (C12R)

4. Staff in this office follow standardized processes to get tasks done. (C15)

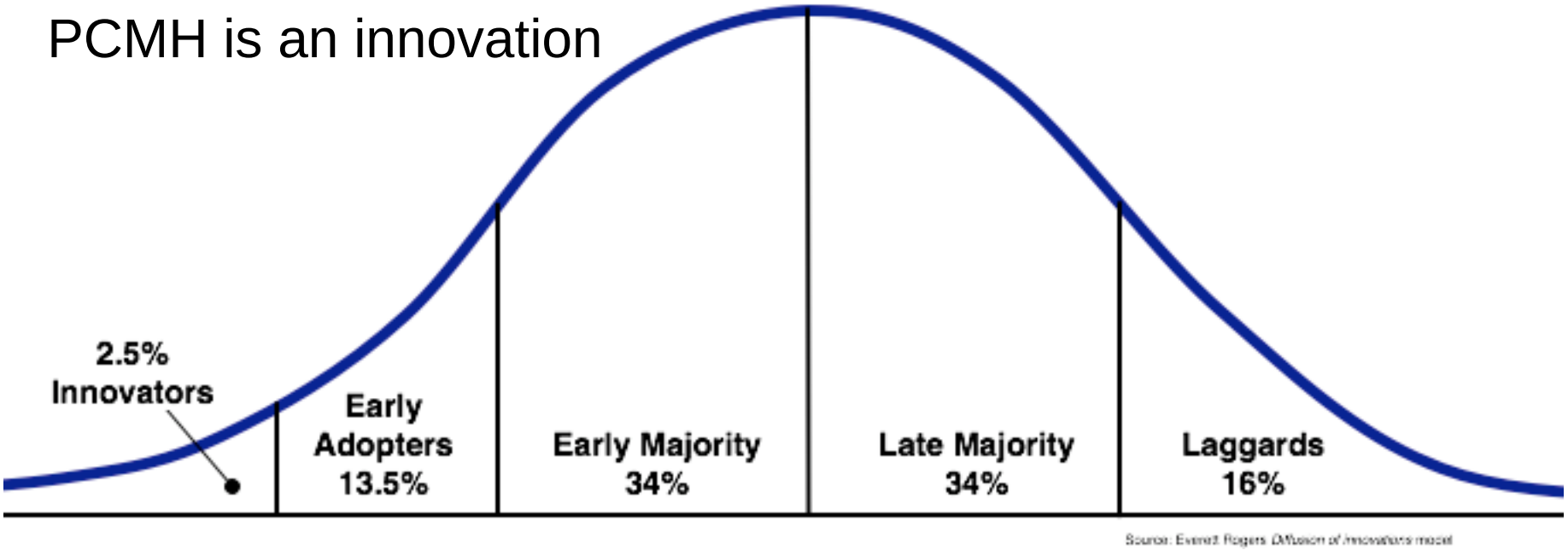
How do we improve workflow in this office and make sure work is done correctly?

Reorganize into care teams for groups of patients

1. Nurse, NP, MD, SW (and Pharmacy available)
2. All inter-visit communications is with a primary nurse who knows the patient
3. Team members communicate face-to-face at least once weekly and all other communication is documented in the electronic record

Summary

PCMH is an innovation



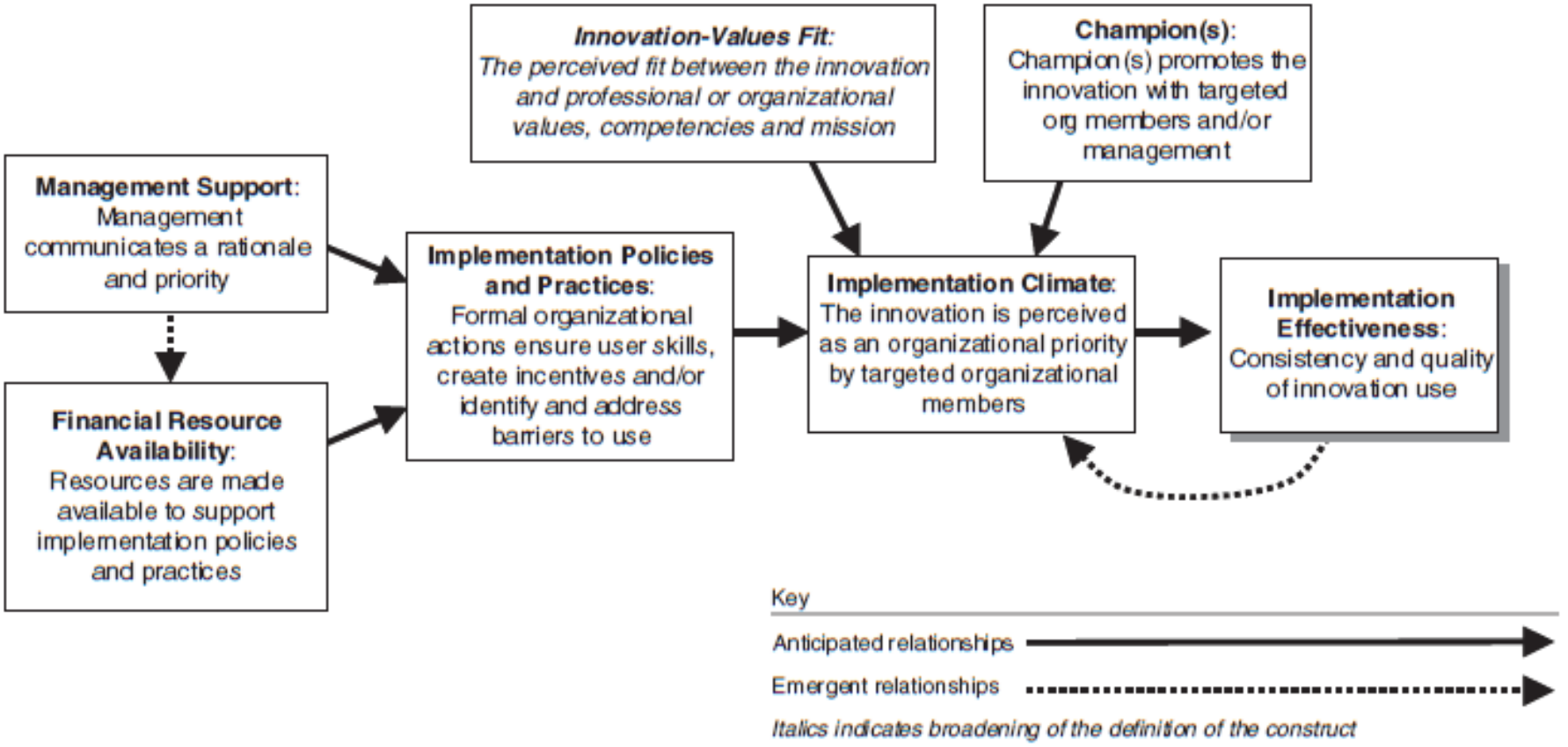
"Getting a new idea adopted, even when it has obvious advantages, is difficult…a common problem for many individuals and organizations is how to speed up the rate of diffusion of an innovation."

Rogers EM. (2003). *Diffusion of Innovations* (5th ed.). New York, NY: Free Press, p. 1.

Challenges to Large Scale Change

- No sense of urgency
- Change is not presented as a clear advantage
- Change is overly complex
- No plan for role modeling and rewarding new behaviors
- Lack of management support
- No champion(s)
- No evidence the change is a priority (flavor of month)
- Lack of resources (time, $, people, equipment)
- Change not hard-wired into policies/procedures, job desc.
- Change is not evaluated

Figure 1
Conceptual Framework of Complex Innovation Implementation



Source: Adapted from Klein and Sorra (1996, 1056).

Helfrich CD, Weiner BJ, McKinney MM, Minasian L. (2007). Determinants of implementation effectiveness: Adapting a framework for complex innovations. *Medical Care Research and Review*;64(3):279-303.

Questions?

University of Nebraska Medical Center