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PROFESSION

Safety research found lacking for outpatient visits

Diagnostic errors, medication mix-ups and other mistakes have been documented in the office-based setting. A new AMA report calls for more research and action.

By KEVIN B. O'REILLY, amednews staff. ***Posted Jan. 9, 2012.***

The past decade saw high-profile private and publicly funded initiatives targeted at the patient safety hazards affecting inpatients, including hospital-associated infections and wrong-site surgeries. Now experts are calling for a similar effort focused on the dangers that afflict outpatients.

In 2000, the Agency for Healthcare Research and Quality set an ambulatory care research agenda to help fill the gap. But the subsequent 10 years amounted to a "lost decade" as outpatient safety research and initiatives took a back seat to problems in hospitals, say the patient safety experts who produced a December 2011 report reviewing about 100 outpatient safety studies from 2000 to 2010.

The report documents widespread patient safety problems in ambulatory care such as incorrect prescribing, misdiagnoses, missed test results and poor communication in physician practices. The report was issued by the American Medical Association's Center for Patient Safety.

As troubling as the findings are, the shortcoming of the outpatient safety research is that it does not say which problems cause the greatest harm and deserve the most attention from physician practices and patient safety experts, the AMA report said.

There is no nationwide estimate of the number of patients who are harmed or killed by mistakes in the outpatient setting. That incomplete picture of outpatient safety stands in stark contrast to the hospital setting, where a 1999 Institute of Medicine report cited research estimating that medical errors kill as many as 98,000 American inpatients annually.

"Looking back on the last decade, we realized that what they had in the hospital setting was the rhetorical focus of the IOM report," said Matthew K. Wynia, MD, MPH, director of the AMA center. "That was in every newspaper editorial, and as difficult as it was to pin down a number and as controversial as it was to put a number on it, it may have been one of the factors that really drove public-policy spending and allowed people to really focus in on the inpatient setting."

The AMA report came as the National Quality Forum for the first time extended its list of serious reportable events, often called "never events," to ambulatory surgery centers, office-based practices and skilled nursing facilities.

There are reasons to believe that a significant amount of patient harm is occurring in office-based care, Dr. Wynia said, noting that ambulatory care patient visits outnumber hospital admissions by 300 to 1. Meanwhile, more than half of the medical liability claims paid are for outpatient adverse events, with two-thirds of those claims involving major injury or death.

A Dec. 14, 2011, commentary Dr. Wynia co-wrote in *The Journal of the American Medical Association* calls for more than just added research. Outpatient safety should be linked to ongoing inpatient initiatives such as the effort to reduce readmissions. Patients and families should be engaged to spot safety problems.

Also, physician organizations, federal agencies and others devoted to patient safety should focus on an "achievable goal" to set a precedent for future initiatives, the commentary said. One suggested target is to improve timely follow-up among outpatients with abnormal lab and imaging test results. Office-based physicians fail to follow up on clinically meaningful abnormal test results 7.7% of the time, said a Sept. 28, 2009, *Archives of Internal Medicine* study.

"This should never happen. Really," Dr. Wynia said. "You ordered the test. Why did you order the test if you weren't going to do something with the result? It's almost like a never event. If you're going to order the test, then what you're going to do with the result needs to be clear."

Importance of measurement

Measuring the scope of the outpatient safety problem will help physician practices target improvements, said David C. Classen, MD, who was consulted on the AMA report and co-wrote the *JAMA* commentary with Dr. Wynia.

"The main problem here is that in the rapidly changing health care world, unless something is viewed as really critical, it will not rise to the top of the list of priorities," said Dr. Classen, associate professor of medicine at the University of Utah School of Medicine. "Nailing down the incidence is the only way you can measure whether all these interventions are really leading to any improvements. There are a lot of evangelical beliefs in patient safety -- that if we just do this, it will get better. But it won't get better if we don't have any reliable way to measure."

AMA President Peter W. Carmel, MD, said the report comes at an opportune time.

"Patient safety in all health care settings is the highest priority for physicians," said Dr. Carmel, a Newark, N.J., pediatric [illegible]

neurosurgeon. "The AMA is pleased to add our new report to the discussion on this critical topic, which is especially timely, as ambulatory care will play an increasingly important role in optimizing quality and cost in new health care delivery models."

The *JAMA* commentary also calls for the development of a national system of clinics to be used as "safety laboratories" to study the effectiveness of quality initiatives. Officials at the federal Agency for Healthcare Research and Quality said such a system already is in place, noting the existence of 130 practice-based research networks nationwide that include 67,000 health professionals and serve 50 million patients. AHRQ officials also noted $74 million in funding in recent years in research on health information technology, which some experts hope will address the coordination-of-care and communication problems at the root of many outpatient safety problems.

A long-term epidemiological study of outpatient safety would need to involve thousands of patients and could cost millions of dollars, proponents say.

"We could use more of that research," said William B. Munier, MD, director of AHRQ's Center for Quality Improvement and Patient Safety. "It's not an easy area to design studies for, I'll tell you that much."

Getting physicians involved

As the wait for more outpatient safety research continues, some organizations are moving ahead in this area. The National Quality Forum's action to expand its serious-reportable events list to cover office-based settings demonstrates how the safety spotlight is broadening to include outpatient care, said Helen Burstin, the organization's senior vice president for performance measures. Deaths or serious injuries due to medication errors, invasive procedures and devices, and failure to follow up on lab results are among the events included in the NQF list, which must be publicly reported by hospitals in 27 states.

"Just to recognize that these are now identified as some of the most important and serious events, internally physician practices should want to understand when these happen, what they can learn from each other, and assess what went wrong to see if there's a way to prevent them in the future," Burstin said. "I suspect that many states that have asked hospitals to report on these events may start asking office-based practices to report as well. Through shared learning, there is an opportunity to figure out what works best to improve patient safety in the outpatient setting."

NQF, the Joint Commission, the National Committee for Quality Assurance and other organizations have endorsed 70 measures pertaining to ambulatory care safety, according to the AMA report.

Shifting attention to the outpatient setting should draw upon doctors' passion for improving care, said Gordon D. Schiff, MD, associate director of the Center for Patient Safety Research and Practice at Brigham and Women's Hospital in Boston.

"Getting our hands around patient safety could be either part of the physician being more beleaguered or put upon to be more on the defensive, having to worry about more things," Dr. Schiff said. "Or it could be really more of a way of making ambulatory medicine fun again -- of really making a lot of the challenge of making the correct diagnosis, as well as getting engaged and excited about making continuous small improvements."

ADDITIONAL INFORMATION:

Top six errors in outpatient care

A decade of research shows that these errors are the most widely documented in ambulatory care, leading to hospitalizations, complications, minor physical harm, psychological harm, lost patient pay, physical injury and death.

- Medication errors such as prescriptions for incorrect drugs or incorrect dosages.
- Diagnostic errors such as missed, delayed and wrong diagnoses.
- Laboratory errors such as missed, delayed and wrong diagnoses.
- Clinical knowledge errors such as knowledge, skill and general performance errors on the part of physicians and other clinicians.
- Communication errors such as doctor-patient communication errors, doctor-doctor communication errors or other miscommunications between parties.
- Administrative errors such as errors in scheduling appointments and managing patient records.

Source: "Research in Ambulatory Patient Safety 2000-2010: A 10-year review," American Medical Association, December 2011 (**www.ama-assn.org/resources/doc/ethics/research-ambulatory-patient-safety.pdf**)

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"Research in Ambulatory Patient Safety 2000-2010: A 10-year review," American Medical Association, December 2011 (**www.ama-assn.org/resources/doc/ethics/research-ambulatory-patient-safety.pdf**)

"Improving Ambulatory Patient Safety: Learning From the Last Decade, Moving Ahead in the Next," *The Journal of the American Medical Association*, Dec. 14, 2011 (**jama.ama-assn.org/content/306/22/2504.extract**)

"Serious Reportable Events in Healthcare -- 2011 Update: A Consensus Report," National Quality Forum, December 2011 (**www.qualityforum.org/workarea/linkit.aspx?LinkIdentifier=id&ItemID=69573**)

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