

First Do No Harm

Quality and Patient Safety Division, Massachusetts Board of Registration in Medicine

Message from QPSD Leadership

Julian N. Robinson, MD
Chair, Board of Registration in Medicine
Chair, Quality & Patient Safety Committee

Daniela Brown, MSN, RN, CIC
Director, QPS Division

Dear Colleagues,

As hospitals in the Commonwealth continue to manage inpatient demands, outpatient settings have also expanded to meet the growing need for services. Care that had been traditionally provided in hospitals has shifted in part to ambulatory settings. This change may result in cost savings and in increased patient satisfaction. Healthcare facilities and clinicians have creatively approached this change to ensure patients continue to receive the quality care they deserve.

In addition, credentialed providers that practice in outpatient settings and hospitals offering ambulatory services must strive to ensure that the same standards of quality and patient safety found in the inpatient setting exists in the ambulatory setting as well. Hospitals offering ambulatory services and independent ambulatory clinics must ensure that they are compliant with the regulatory requirements found in 243 CMR 3.00 which govern the Massachusetts Board of Registration in Medicine's (BORIM) Patient Care Assessment (PCA) Program. In this issue, we share some of the exciting innovation and experiences in ambulatory settings from healthcare facilities that report to the QPSD.

The Quality and Patient Safety Division (QPSD) together with the Board's Quality and Patient Safety Committee will be exploring the possibility of providing small group, educational workshops for our Quality and Risk Management colleagues that report to the QPSD. These educational workshops would be offered virtually in 2022. The QPSD is requesting assistance in determining possible topics for these workshops. If interested, please refer to page five of this newsletter for additional information.

Finally, the plan to transition to electronic reporting of the Annual, Semiannual, and Safety and Quality Review (SQR) reports is in progress and will provide the hospitals and ambulatory clinics that report to the QPSD a secure and efficient method of reporting that will improve the user experience. As we move forward, we may request that several of the healthcare facilities that report to the QPSD consider assisting in this process by becoming a "test user". More information regarding timelines, onboarding, and training will soon be available and will also be communicated directly to PCA Coordinators.

Best,
Julian N. Robinson, MD and Daniela Brown, RN

This newsletter is issued by the Board of Registration in Medicine (BORIM), Division of Quality and Patient Safety (QPSD). The newsletter allows BORIM to share the practices and experiences of the healthcare clinicians and facilities that report to the Board. It does not necessarily include a comprehensive review of literature. Publication of this newsletter does not constitute an endorsement by the BORIM of any practices described in the newsletter and none should be inferred.

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UMass Memorial Medical Center Advancing Ambulatory Quality and Safety through Relationships and Coordination

Kimiyoshi J. Kobayashi, MD, MBA, Chief Quality Officer

Janell Forget, RN, BSN, JD, CPHRM, AVP Risk Management

Andrew Karson, MD, MPH, Chief Medical Officer

A patient in their 60's presented to an ambulatory clinic with complaints of shortness of breath and other symptoms which were concerning for a cardiac etiology. During the visit, the patient had an EKG which was misinterpreted by the outpatient physician. Based on the procedure at that time, the study was not sent for further formal diagnostic interpretation or verified by a second provider.

This was a case brought forward by the clinic and it propelled UMass Memorial Medical Center (UMMMC) to review our processes for EKG studies performed in the ambulatory setting. A multi-disciplinary root cause analysis was performed and identified that overreads of EKGs were not being done consistently by the providers in the ambulatory setting and it was determined that there was a gap in knowledge about how to utilize our electronic systems to review and submit EKGs for formal cardiology interpretation.

The above serious adverse event is just one of many examples that are submitted by our ambulatory clinical teams; these submissions play a major role in helping to improve quality and safety. Since 2019, there have been six Safety and Quality and Reviews (SQR) reports from our ambulatory practices. The ambulatory practices within UMMMC utilize the same structure for reporting and investigating events that is used across all of our clinical realms. The risk management team focuses on developing relationships with clinical departments to encourage reporting of events as a means to improve care. One way this has been accomplished is by having a dedicated risk manager focused on ambulatory cases. Further, within the organizational Center for Quality and Safety there are other team members specifically focused on ambulatory care, spanning domains from patient safety to infection control. These ambulatory-oriented team members work closely with departmental Physician Quality Officers and Ambulatory Practice Leaders who also have ongoing quality improvement initiatives.

UMMMC also integrates an ambulatory focus within the organizational leadership structure for quality and safety. The Chief Quality Officer is accountable to both the medical center and medical group. The Quality and Safety Steering Committee oversees quality and safety issues in both the inpatient and outpatient arenas. There are also close collaborations and regular interactions among the leaders responsible for health system quality, Accountable Care Organization quality, and Patient Experience. These close partnerships have enabled collaborative programs in areas such as readmissions, health equity, and incidental findings management.

We firmly believe that having both close collaborations at the local clinic level, as well as coordination and integration with organizational quality and safety mechanisms drive continued advancement of ambulatory quality and safety.

For more information on UMass Memorial Medical Center's efforts on ambulatory quality, please contact Kimi Kobayashi, MD, MBA Chief Quality Officer at Kimi.kobayashi@umassmemorial.org, Janell Forget, RN, BSN, JD, CPHRM, AVP Risk Management at Janell.forget@umassmemorial.org, or Andrew Karson, MD, MPH, Chief Medical Officer at Andrew.karson@umassmemorial.org.

Same Location, New Address

The QPSD has a new mailing address. Please send all future correspondence to:

The Quality & Patient Safety Division
Massachusetts Board of
Registration in Medicine
178 Albion Street, Suite 330
Wakefield, MA 01880

QPSD Reporting Reminders:

Annual and Semiannual Reports for Non-Acute Care Hospitals and Acute Care Hospitals without inpatient maternal newborn services are due on

November 30, 2021

Quarter Four Patient Fall and Pressure Injury Reports are due on **January 30, 2022**

South Shore Hospital Leveraging Hospital-based EMS to Facilitate Continuity of Care and Business Recovery During COVID-19

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Emergency Medical Services (EMS) is more than transporting patients to the ED; it is a practice of medicine. In a fully integrated EMS system, providers can leverage the clinical acumen and procedural skills of a paramedic to care for patients in both traditional and non-traditional settings.

Never has this been more important than during the COVID-19 pandemic. The recently launched the Mobile Integrated Health (MIH) program at South Shore Hospital has become an integral part of the health system's response to the deadly virus. Through MIH, patients with limited access to care, chronic health needs, or who are at high risk for readmission or use of the emergency department, are identified by Primary Care Providers (PCP) and ED providers. EMS professionals then respond using evidence-based protocols combined with active medical control to provide immediate care in the home and connect patients with community resources or clinics.

As the spread of Covid-19 accelerated, patients became unwilling or unable to seek care in the hospital. Primary care clinics closed, elective surgeries cancelled, and nursing facilities became overrun and overburdened. Immediately, the MIH team of specially trained paramedics – mobile, flexible, and connected – was able to pivot to augment the sudden gaps in care. As a hospital-based service, integrated with the organization's electronic health records system the MIH program quickly became an essential tool to “flatten the curve.” Now, it cares for patients in need, and leveraged for business recovery.

Pre-pandemic a key system focus was to improve system capacity and contain costs. The MIH program combines basic telehealth technology and a strong partnership with Visiting Nurse

Association (VNA) and other home health services, proving that cost-containing, innovative practices don't always require high-tech solutions. By including the capabilities of out of hospital programs, South Shore Health's MIH program is able to improve access and quality, while also embracing patient and family-centered care principles.

Today, patients who traditionally would require hospital admission for certain diseases, such as pneumonia, congestive heart failure, chronic obstructive pulmonary disease, and cellulitis now receive hospital-level care in their homes, through MIH, as a substitute for acute hospitalization. Paramedics provide physical assessment, lab acquisition, infusions, IV antibiotics, wound care, EKGs and other critical services in the patient's home while connected to hospital-based providers and specialists who easily consult. Augmenting this acute care with the skills of traditional home health services (VNA, Home PT/OT), patients are cared for in a dynamic fashion without ever needing the physical footprint of the hospital.

After 1 year of service, the South Shore Hospital EMS team has made 2213 in-person patient visits, 3555 telehealth provider visits and managed to intercept 302 ED visits by high-utilizers. Agnostic to the payer and funded by telehealth reimbursement, Accountable Care Organization (ACO) or practice-based contracts MIH operates with a cost avoidance strategy focused on preventing readmissions and reducing bed hour utilization.

By combining MIH-type services with telehealth, alongside other services like VNA, Hospice and 911, health systems can create capacity while embracing patient-and family-centered care while creating increased capacity for novel care within the existing footprint of the hospital.

Boston Medical Center

Telephone Nurse Triage Protocols

Stephanie Martinez MBA, BSN, RN, CPHQ

Associate Chief Nursing Officer, Ambulatory
Services, Boston Medical Center

In early 2020, Ambulatory Nursing at Boston Medical Center (BMC) participated in a multidisciplinary hospital- wide risk assessment performed by our Quality & Patient Safety department. The purpose was to proactively identify evolving patient safety risks throughout the organization, prioritize key gaps

and implement workflows to mitigate risk. BMC's ambulatory practices see almost a million patients every year. In the Ambulatory clinic setting at BMC, telephone nurse triage was identified as a potential risk due to lack of real-time access to evidence-based care advice resources for triage nurses, inconsistent medical record triage documentation, and no data driven process for ongoing review of telephone triage performance. Based on these findings, our goal was to develop a telephone nurse triage system to provide safe, consistent, efficient, and quality care for our patients, as well as to limit malpractice liability. To address the identified gaps, BMC invested in an IT solution to sub-license Dr. Barton Schmitt's pediatric (Schmitt, 2018) and Dr. David Thompson's (Thompson, 2018) adult telephone triage guidelines.

The newly implemented evidence-based triage protocols and guidelines are now utilized in all of our pediatric and adult ambulatory clinics that provide primary care services. These protocols are integrated into our electronic medical record, offer decision support and assist to provide standardized, symptom-based care advice with less variation in practice between nurses. Utilizing existing evidence-based triage protocols and adapting them as necessary to meet our needs rather than writing our own has been very beneficial. If modifications were made, they have been standardized across providers within practices to minimize confusion for our triage nurses. Determining the acuity and urgency of a patient over the phone is not part of basic nurse training and can be complicated because the triage nurse does not have the ability to assess the patient by sight. Utilizing these protocols has improved the efficiency and knowledge for our experienced nurses and has allowed us to train new nurses to the Ambulatory setting over a shorter period of time because of the additional prompting and support provided by the protocols.

Formerly our nurse triage documentation was primarily free text in nature, which led to the potential for substandard telephone notes with a high degree of variation. This left both the organization and care team at risk with variable assessment of patient symptoms influenced by individual nurse training and experience. The embedment of symptom-based protocols into our electronic medical record prepopulates questions and recommendations based on the patient responses documented by the nurse. Our triage call

documentation now routinely includes the protocol used, instructions for follow-up, dosage of any over the counter medications recommended, and disposition. This allows providers to be more comfortable with patient assessment as the nurses triage by protocol with standardized documentation, reducing the risk of litigation. If a patient has an adverse outcome, the triage call documentation provides evidence of what was discussed and recommended during the telephone encounter. Additionally, the improved documentation has provided BMC with performance data to assist in identifying nurses that may need additional training and support, as well as recognize high performers.

This solution has provided our triage nurses with the tools to deliver timely and effective care advice over the telephone and ensures clinical safety and consistency of responses to symptom-based questions from patients.

Our next priority areas for implementation include specialty clinics. For these areas, we will be creating custom protocols based on recommendations from professional associations which incorporate published research findings.

References:

- Schmitt, B. D. (2018). Pediatric Telephone Protocols, Office Version, 16th Edition. American Academy of Pediatrics.
Thompson, D. A. (2018). Adult Telephone Protocols, Office Version, 4th Edition. American Academy of Pediatrics.

Boston Out-Patient Surgical Suites, LLC

Gregory P. DeConcillis, PA-C, CASC

Administrator

I often use the analogy of a pit crew when I reference efficiency in the ambulatory surgery center (ASC) setting. With reimbursement markedly less than similar hospital outpatient settings, ASC's must ensure that efficiency, along with a reduction in medical costs, are in constant focus. However, I do not want to mistake efficiency for sacrificing quality and safety. It is quite the contrary, and why I use the analogy of the pit crew. Members of a pit crew each perform a different task, safely and effectively, so that the sum of these tasks being performed produces an excellent outcome. I think we all can agree that safety and quality are vital in race-car driving.

I believe that efficiency is a challenge for many facilities. Leaders often try and solve efficiency concerns by hiring more staff. Unfortunately, this typically results in less efficiency. The effect is more people standing around, thinking the other person will perform the task, instead of doing it themselves. Efficiency is doing things correctly, to the best of one's ability, once.

Efficiency needs to be studied. Often, efficiency cannot just be directed by a manager or leader of the organization, unless they have actually worked in that environment and performed those tasks themselves. Efficiency needs to come from experience, and leaders need to lean on staff members, who live in the environment every day, to direct them on how to improve efficiency. Direct supervisors know which employees are the best at their respective tasks, and those individuals should be the ones who direct other employees. These same employees should be applauded and encouraged to share their efficiency tips with others. The side effect of efficiency is an organization that runs a lot smoother, with increased throughput. This leads to higher physician, staff, and patient satisfaction. This results in improved overall quality.

When tasks and operations are studied for how to be performed best, seeking input from others, they will be improved in some fashion. Not only will they be performed more accurately, and effectively, but they will be performed more safely overall.

An example of a prior efficiency improvement occurred in our Operation Room turnover. We studied, through observation and interviews, what the key components were to room turnovers. We then held an "all-hands" in-service to finalize recommendations, establish roles, and determine the implementation plan. We followed our plan, and the result was a decrease in turnover times, which led to a more consistent operating room schedule, and happier surgeons and patients. We maintained all infection control standards and outcomes.

Another example occurred with physician surgical preference card management. Our system was archaic, and our cards were not analyzed and updated consistently. We selected knowledgeable personnel to take the lead on updating these

cards, developing a system for consistent updates, and measuring effects. The result was higher quality and outcomes, along with a reduction in medical waste. Our surgical procedures proceeded in less time, which again, led to higher surgeon and patient satisfaction.

As we see volumes start to increase to pre-pandemic levels, we will see the return of our busy schedules. Now is the perfect time to meet with key members of your organization and analyze those pesky bottlenecks, and areas that need improvement. Now is the perfect time to become more efficient.

QPSD 2022 Workshops

The Quality and Patient Safety Division (QPSD) together with the Board's Quality and Patient Safety Committee is planning to host small group, virtual workshops for our Quality and Risk Management colleagues and PCA Coordinators.

These educational workshops would be offered virtually in 2022. The QPSD is requesting assistance in determining possible topics of interest. Please email qpsd.conference@mass.gov with suggestions. Currently, possible topics may include writing Safety and Quality Review Reports, the peer review process, the role of leadership in the PCA program, maternal levels of care, and reporting of type IV events.

Please note that this is not a link for registration. Communication regarding workshop dates and registration will be announced at a later date.

Thank you.

Questions and comments may be directed to
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