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**The Princeton Conference**  
**“20 Years After to ‘Err Is Human’—Where Next?”**  
**Challenges in Outpatient Safety within VA**

# High priority areas of outpatient safety

- **Diagnostic error**—missed opportunities in diagnosis
- Timely **follow-up** of abnormal test results to prevent care delays (such as delays in cancer diagnosis)
- **Fragmentation of care** for opioid and other medications
- Closing the loop on **referrals** to prevent care delays

# Diagnostic error

- Frequency: about **5%** or **1 in 20** U.S. adults experience a diagnostic error each year
- Common diseases missed include cancers, cardiovascular disease, and infectious diseases
- Often due to **failure to elicit or act** upon key history/exam findings
- At times, clinicians **overlook** documented critical information in the EHR

# First step: Identify diagnostic safety concerns

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- **E-Trigger queries** are being developed that can alert safety personnel of possible adverse events—a step toward learning and improvement
- **E-trigger algorithm queries** for a selective ‘high-risk’ sample in an EHR data warehouse

**BMJ Quality & Safety**

**Application of electronic trigger tools to identify targets for improving diagnostic safety**

# Closing the loop on test results

- Evaluation of 1,163 outpatient abnormal lab and 1,196 abnormal imaging test result alerts
  - **7% abnormal labs** lacked timely follow-up
  - **8% abnormal imaging** lacked timely follow-up
- Abnormal test results continue to get missed in health IT-based settings
  - issues related to **workflow, responsibility of follow-up, information overload** and **technical issues**



# Fragmentation of care contributes to opioid overdoses

Annals of Internal Medicine

EDITORIAL

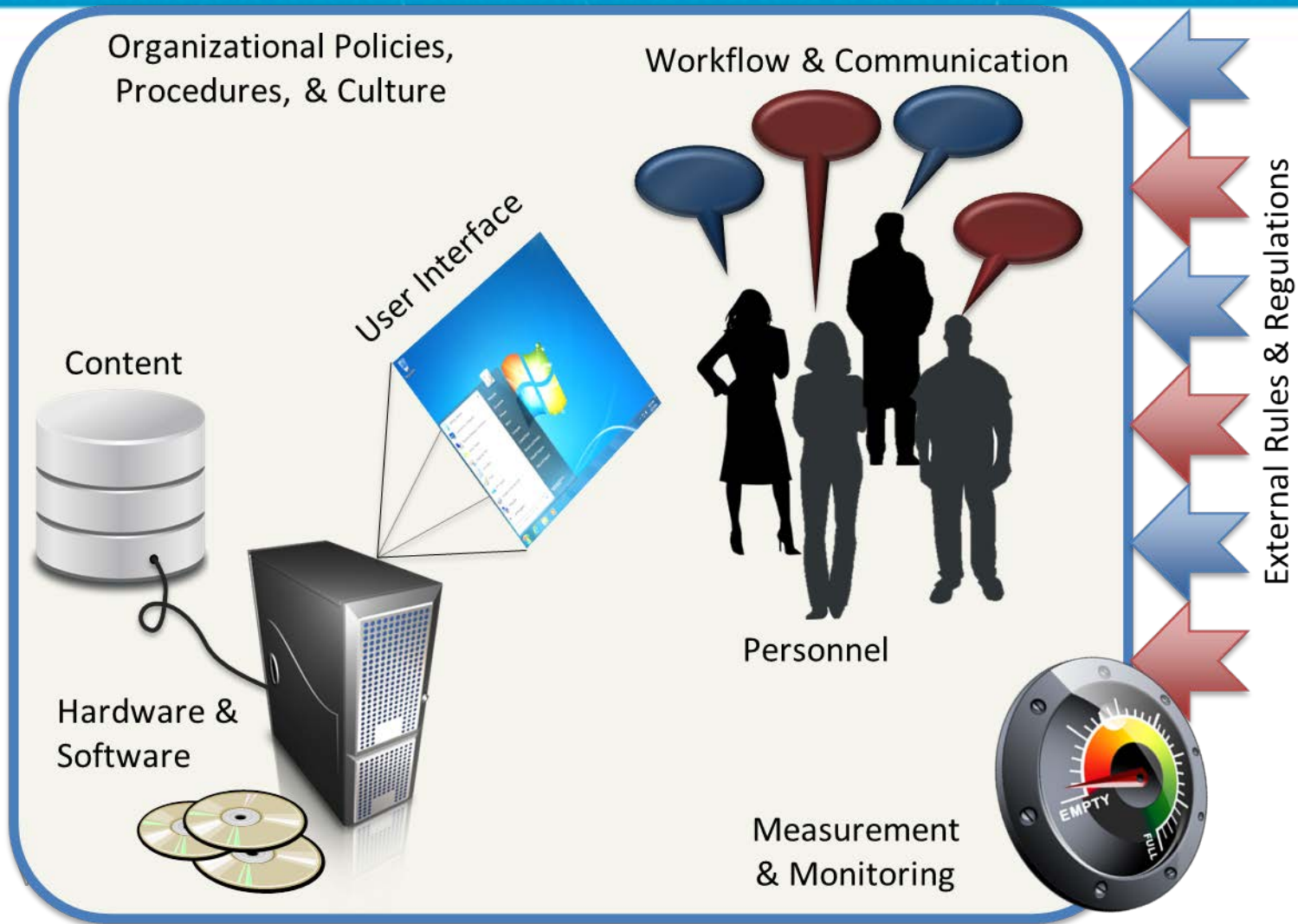
## Care Fragmentation and Prescription Opioids

According to some estimates, up to 80% of Americans who are now addicted to an opioid were first exposed through a prescription, either their own or that of a friend or family member (1). The dramatic increase in prescription opioid use (especially long-acting formulations) has been associated with 2 interrelated factors: clinicians' well-intended focus on pain as the fifth vital sign and the faulty premise that appropriate use of opioids for treating chronic pain does not lead to addiction. In addition, at least 1 study shows that increased prescriptions are correlated with marketing efforts by drug manufacturers (2).

Although overall sharing of medical records to improve care coordination remains far from routine (because of technical and other barriers), checks of state-run prescription drug monitoring programs (PDMPs) may offer an important alternative for identifying patients at risk. State PDMPs, which have been expanding greatly over the past decade, are one approach to the problem of managing care of patients who require opioid analgesics and receive them from several providers.

As Moyo and colleagues note, data show decreased overdoses when state PDMP checks are used (5). Because PDMPs are controlled by states, data stan-

# Sociotechnical approaches to understand and fix problems



## Vulnerabilities in the referral process

- Responsibility moves between PCP & specialist
- Handoff of important clinical information
  - Each step at risk of breakdown
- The EHR is valuable at PCP-specialist interface, but what about outcomes at 30 days?
  - **6.3% of EHR referrals** w/ unexplained lack of follow-up actions by subspecialists
  - **7.4% of discontinued referrals** returned to PCPs w/ unexplained lack of follow-up



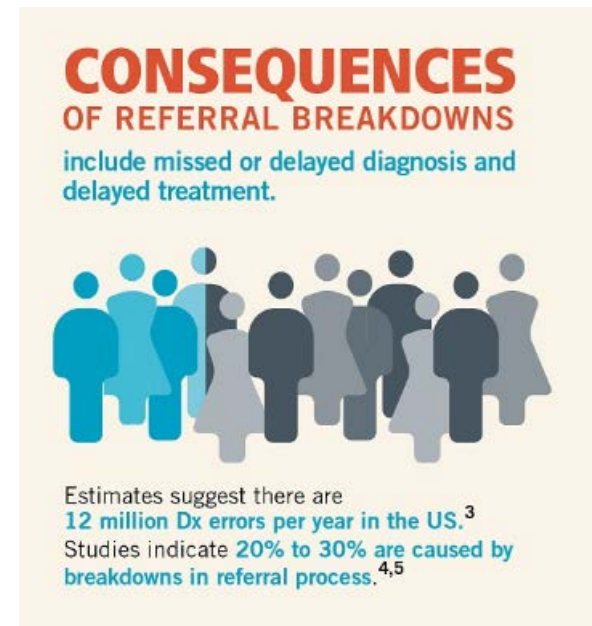
# Closing the loop on ambulatory referrals

## “Closing the Loop: A Guide to Safer Ambulatory Referrals in the EHR Era,”

*Institute for Healthcare Improvement*

### Recommendations:

- Ensure interoperability between EHR systems
- Conduct a proactive assessment of electronic communication
- Use collaborative care agreements to define expectations
- Improve and standardize handoffs
- Develop process to define accountability for patient follow up
- Develop method to track referral status



# Actionable measurement of safety

## Health systems can:

- **identify safety concerns** for quality improvement, learning, and/or research purposes
- **measure outpatient concerns for improvement** *not* for public reporting, performance measurement, or penalties
- **build a “Learning Health System”** to improve diagnostic safety (VA’s mission to become HRO)
  - The Safer Dx Learning Lab—part of VA Center for Innovations in Quality, Effectiveness and Safety (iQuEST)

# VA's approach to outpatient safety

- Think systems and learning health approaches
- Actionable measurement: find, learn, and fix
- Implement best practices to close the loop on test results and referrals
- Patient engagement
- Better use of information technology

## Beyond integrated systems: action steps

- **Accreditors** can verify existence (and effective use) or identifying error-prone systems
- Actionable measurement: find, learn, and fix
- **Incentives**: “safe harbors” for systems that demonstrate focus on high reliability (?)
- Patient engagement, e.g. MA requirement for advisory councils; effective patient / family / caregiver education

# Questions & discussion