



**Proactive Reduction in Outpatient Malpractice:
Improving Safety and Efficiency and Satisfaction
(PROMISES)**

**Case Study
Dr. Damian Folch, Chelmsford, MA**

Practice Improvement

Leadership in Patient Safety

“Leadership is fundamental for healthcare improvement.” –Damian Folch, MD

*“In a solo practice, the big problem is that you have to do everything;
the good problem is that you can change on a dime.”* –Damian Folch, MD

This case study is part of the PROMISES Malpractice Reform Project—a project to proactively reduce outpatient malpractice that was funded by the Agency for Healthcare Research and Quality. Both interventional practices and control practices were enrolled in a randomized controlled trial (NCT01758315). PROMISES assembled a high-level Massachusetts consortium to test the impact of powerful quality improvement techniques to accomplish innovations and improvements in high-risk ambulatory malpractice areas. PROMISES sought to investigate and identify improvement in three key areas (test result management, referral management, and medication management) and a “plus one” area (overarching communication issues). Interventional practices received intervention and advice; control practices did not. Dr. Damian Folch’s Practice was one of the interventional practices.

LEARNING OBJECTIVES

After reading this case study, you will be able to:

- Tell why change does not always produce expected results
- Describe how improvement changes can be redirected
- List how involving all staff members can produce more ideas

INTRODUCTION

Dr. Damian Folch is a solo practitioner located in Chelmsford, MA, with a panel size of approximately 3,500 patients. Dr. Folch agreed to work with the PROMISES project and identified two areas for potential improvement: (1) closing all “open loops” and, (2) increasing the return rate of Fecal Occult Blood Tests (FOBT) for patients reluctant to have a screening colonoscopy.

Several years ago, Dr. Folch’s practice implemented an electronic medical records (EMR) system. The EMR creates an open loop whenever a test or referral is requested. These open loops can require manual matching of records to close. Patients may have received test results and the needed care, but the documentation was buried in visit notes (and the EMR loop was not closed). Baseline data showed that there were over 45,000 cases where the loop had not been closed. The practice realized they needed to close these existing loops and create a process where future loops were consistently closed.

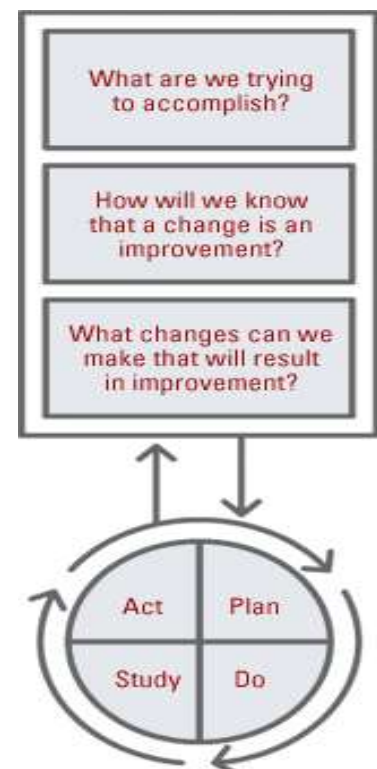
Dr. Folch was also concerned with the low rate of colorectal screenings performed. He wanted to focus attention on patients reluctant to have a screening colonoscopy by offering them an FOBT to perform at home. Though 43% were generally returned, Dr. Folch wanted a 90% return rate.

USING THE MODEL FOR IMPROVEMENT (MFI)

AIM: What are we trying to accomplish?

This practice had two aims:

1. To close all current open loops and develop a new process where no loops were left open without cause.
Target date: 15 months.
2. To increase the number of patients returning FOBTs from 43% to 90%. Target date: 6 months.



Developed by:
Associates in Process Improvement

MEASUREMENT: How will we know that a change is an improvement?

The improvement measures were:

1. Number of open loops older than a month (not including tests ordered for future dates)
2. Number of FOBT kits returned within a month

CHANGES: What change can we make that will result in improvement?

1. Change to close open loops—Train the staff to understand the importance of closing the loops and to close the loops whenever time allows. Prediction: Although slow and tedious, loops could be closed at an acceptable rate.

2. Change to improve the return rate of FOBT tests—Increase the response rate by calling the patient after one week with a reminder to return the kit and to answer any questions. Prediction: A significant increase in FOBT returns rate percentage (but maybe not 90%)

Having answered the first three questions in the Model of Improvement—aim, measurement, and change—the practice was now ready to run the first Plan-Do-Study-Act cycle.

PLAN-DO-STUDY-ACT (PDSA) CYCLES

1. Change: Closing the loops

The first change the practice tested was closing the open loops. Everyone was required to close loops in addition to their other assigned work.

PLAN

Dr. Folch spoke with the staff and told them that all the loops had to be closed “no matter what.”

DO

The staff worked to close the loops, however this task proved to be more daunting than anyone had predicted. It was boring and difficult to work continuously on open loops while being interrupted by regular duties.

STUDY

The staff worked diligently to close the loops. Each test result had to be reviewed and documentation updated. However, at the current rate of loop closure, they would be working on this for a very long time. Additionally, the staff was becoming increasingly frustrated by the tedious nature of the task.

ACT

Dr. Folch decided to abandon this particular loop closure method and called a staff meeting to explore more efficient and less stressful ideas. That meeting generated the following ideas and each was put through a PDSA cycle.

1. Separate the cases into smaller groupings and give staff members a dedicated amount of time to work on them without interruption
2. Close the office for a time period(s) so all staff could close loops
3. Design a new process to insure that lab results are addressed on a monthly basis and loops are not left open

Conclusion

After putting each idea through a PDSA cycle, Dr. Folch and his staff realized that closing the loops required closing the office so that all the staff could dedicate time to the task. Though still tedious and boring, Dr. Folch convinced his staff of the importance of the work; consequently, they were all invested in getting it done. Dr. Folch himself participated by addressing all the test results that required notifying the patient. After closing 45,000 loops, it was apparent to everyone that a new process was needed to insure that they would never be faced with this problem again. Together, with his staff, Dr. Folch developed a method whereby each month all open loops are addressed. Today they are confident that all test result loops have been closed.

2. Change: Fecal Occult Blood Test return

The second change the practice worked on was increasing the rate of return of the FOBT kits given to patients unwilling to have a screening colonoscopy.

PLAN

Staff from Dr. Folch's office planned to call patients who had not returned the test within a week. The staff would remind patients about the importance of this screening and ask if there were any questions.

DO

The staff called patients who had not returned the test. They often had to leave voice mails and patients were still not motivated to complete and return the FOBT.

STUDY

The return rate increased from 43% to 57%.

ACT

The return rate did increase, but still did not reach the 90% goal. Realizing that this new process was not as effective as he wanted, Dr. Folch once again met with his staff to explore ideas and options. He emphasized the importance of what they were trying to do by using the experience of his own father's death from colon cancer and examples of patients whose lives were saved by using the FOBT cards. The ideas generated from that discussion were:

1. Create a form letter from Dr. Folch to the patient (in both English and Spanish)
2. Meet with staff to brainstorm ideas to improve the return rate
3. Include a picture of Dr. Folch in the form letter making it more personal and friendly
4. Increase the emphasis on FOBT return when originally handing the test to the patient
5. Call patients who have not returned the test in two weeks and then again in two months. If still no response, have Dr. Folch call the patient to emphasize the importance.

CONCLUSION

Dr. Folch has not yet tested all the change ideas that he and his staff generated. He wants to have further planning meetings with his staff and decide which to try next. Though the rate of returned FOBT cards is still lower than the 90% goal, there are still many stories of individual patients whose lives have been positively impacted by the persistence of Dr. Folch and his staff. Dr. Folch enthusiastically shares these success stories to keep himself and his staff motivated and actively engaged in finding alternatives.

SUMMARY

Dr. Folch demonstrated the importance of leadership in patient safety through his participation in these two examples. As an effective leader, he both listened to and effectively directed his staff, bringing about an enthusiastic desire to change even when the tasks were tedious and success was at times elusive.

"I can tell you that patient safety is addressed and I sleep much better at night." – Damian Folch, MD

RELATING TO YOUR PRACTICE

1. Staff may be more open to improvement ideas if they understand the reason why change is important and they provide input into change procedures.
2. Try to plan a meeting or find a way to open a dialogue.
3. Leadership is being willing to include others' opinions.
4. Do not be afraid to risk failure. Not all tests of change are going to work. It is through failure that ideas are modified and lessons are learned; both provide valuable information for designing future tests of change.

ASSESSMENT QUESTIONS

In this practice, the physician decreed that the loops

- a) Had to be closed no matter what
- b) Were important to close
- c) Had to be closed in addition to regular work
- d) All of the above**

In this practice, when the FOBT return rate was less than ideal, they

- a) Sent patients another stool card
- b) Called the patients daily with a reminder
- c) Created a friendly form letter to send to patients**
- d) Reminded the patient during their upcoming yearly physical

In this practice, when the loop closing results were less than ideal, they

- a) Kept to their original plan without changing
- b) Stopped, regrouped, and brainstormed new ideas**
- c) Worked overtime to increase the close rate
- d) Hired extra workers to help close more loops