Proactive **R**eduction in **O**utpatient **M**alpractice:
Improving **S**afety and **E**fficiency and **S**atisfaction
(PROMISES)

Case Study
North Shore Physicians Group, Beverly, MA

Engaging Specialists in Improvement

Tracking Referrals

"We were tracking paper, not patients." – Lorraine, Practice Manager

"It has given me a chance to feel involved in a patient's care—and that is really nice" – Amy, Patient Support Representative

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. North Shore Physician Group in Beverly was one of the interventional practices.

LEARNING OBJECTIVES

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

- List the different types of changes that can be considered
- Describe an open or missing feedback loop
- Define a small test of change

INTRODUCTION

North Shore Physicians Group (NSPG) of Beverly, MA, is a three (full-time) physician primary care practice affiliated with North Shore Medical Center with a panel size of 4,600 patients. NSPG agreed to work with the PROMISES project and identified an area for potential improvement: inefficient follow up of screening colonoscopy referrals.

The NSPG process for referring patients for a screening colonoscopy was to send the referral by fax to the Gastrointestinal (GI) group. There was no feedback loop in place; NSPG could not verify whether the fax was received, or where the patient stood in the process. Baseline evaluation showed that patients were booked for appointments far out, not showing up for appointments, or not being contacted at all. NSPG also realized that the faxes sent were sometimes lost in transmission. The only follow up a patient received was when they themselves called either NSPG or the GI practice to inquire about making an appointment.

USING THE MODEL FOR IMPROVEMENT (MFI)

AIM: What are we trying to accomplish?

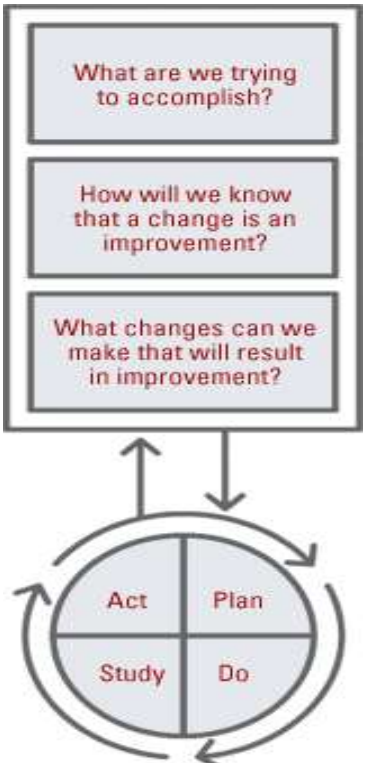
NSPG's aim was to implement a process during the next 12 months allowing them to track 100% of their patients through the steps following a screening colonoscopy referral—and to reduce the amount of time the patient waited in each step of the process.

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

NSPG chose to measure the number of patients tracked by the new system. The goal was always to know every patient's stage in the process.

They also measured the:

1. Time from referral to first attempted contact with patient by GI office
2. Time from patient contact by GI office to appointment booked
3. Time from appointment booked to actual appointment
4. Total time for the entire process
5. Time from screening appointment to primary care physician receiving report



Developed by:
Associates in Process Improvement

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

During the planning meetings with the GI group, the NSPG staff constantly asked about the process in place when a patient did not respond to the initial phone call from the GI group. They were also concerned about the process when a patient canceled or 'no-showed' an appointment. By talking through the many different scenarios together, they were able to identify process steps that could benefit from improvement. NSPG wanted to work with their office staff, their information technology (IT) team, and the GI group to ensure that everyone working on referrals had input into the new process development. All worked to develop a plan to improve the process using small tests of change. Lorraine, the office manager, described the incremental change as, "We didn't want to boil the ocean."

The changes the planning meetings identified included:

Technology—Implement some technology changes in the referral process:

1. Reduce the time needed to make referrals
2. Reduce and streamline the ability to track patients through the process
3. Create a template to pre-populate patient information directly to the GI group
4. Create an electronic feedback loop

Communication—Develop patient letters for:

1. No-response to calls from the GI group
2. Cancelled appointments
3. No-show appointments
4. Patients wanting a reminder letter to make an appointment at a later date
5. Education about the importance of a screening colonoscopy
6. Providing the option of using a stool card as an alternative to a screening colonoscopy

Process—Develop a new process with the GI group:

1. Determine the expected time for each part of the process
2. Reduce turnaround time between patient referral and appointment
3. Provide NSPG with a turnaround time report

Having answered the first three questions in the model for improvement—aim, measurement, and change—they were now ready to run their first Plan-Do-Study-Act MFI cycle.

PLAN-DO-STUDY-ACT (PDSA) CYCLES

One change aimed to close the loop with patients that had been called but did not have a test booked. The team tested a standard form letter developed in partnership with the risk manager that informed patients about the importance of a colonoscopy.

PLAN

The team planned to pilot test the form letter with a few sample patients. When the GI team sent the names back for the next five patients, the front desk planned to print and mail this letter to the patients. The team would then track these names for a month to see if patients called to follow up.

DO

When the GI group sent the patient names, the form letters were successfully sent out. The letter included information for receiving a stool card if the patient did not want a colonoscopy.

STUDY

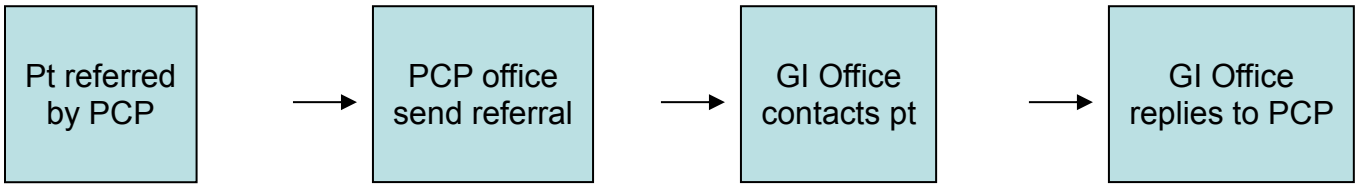
NSPG kept track of the sample patients on a spreadsheet. They realized there were additional scenarios the first letter did not meet (e.g., patient request for a reminder in 6 months).

ACT

NSPG decided to adapt their plan. Working with their risk manager, they edited the letter. Feeling confident that the letter was improved, they planned to test it for another PDSA cycle. They also developed additional form letters to cover other situations. They then tested those new letters with PDSA cycles.

CONCLUSION

After many PDSA cycles which included changes to technology, communications, and process, NSPG finalized and adopted the process of making and tracking screening colonoscopy referrals. The process was documented and all staff trained so that it is consistently carried out. Currently, no other process can be used to make a referral, reducing almost all the variation in the process. Their process steps are:



With each change, the practice tracked several patients to see how the process worked. By doing a series of small tests, they were able to adapt their process as needed. Triggers were built into the process so each patient received the appropriate letter when needed. The turnaround times were reduced and patients are no longer booked months out for their appointments. NSPG always knows where patients stand in the process and when additional intervention is needed. NSPG has reached their goal of tracking all patients that have been referred. The GI office has observed an increase in colonoscopy screenings. Both offices now receive fewer calls from upset patients.

Updating the referral process created a better workflow for both NSPG and the GI office. The staff is happier because they are receiving fewer calls from concerned patients and everyone feels that they are providing better care. NSPG is also making plans to share their findings and help other primary care practices implement the same process. Based on this success, NSPG aims to work with other specialists and streamline those referral processes. The GI group recognizes that there are still patients from other primary care practices that would benefit from a similar process re-design. They are hopeful that someday all primary care physician offices will use this type of referral process.

The fax is the dinosaur in the Stone Age. Now we have it [the referral history] electronically and we can keep it in their record. –Jen, Business Manager, GI practice

RELATING TO YOUR PRACTICE

1. Reach out to specialists to develop ways to help both offices work more efficiently
2. Listen to patient concerns. If you are receiving repeat phone calls about the same concern, it may be time to consider a new process.

ASSESSMENT QUESTIONS

In this practice, the changes identified included

a) Technology changes
b) Communication changes
c) Process changes
d) All of the above

In this practice, they wanted close the open loops by

a) Working and planning with the GI group
b) Sending duplicate and triplicate referrals
c) Booking the hospital appointment themselves
d) Speeding things up ("boiling the ocean")

With each small test of change, this practice

a) Assumed it would work since it was so small
b) Chose 100 patients to track initially for evaluation
c) Tracked several sample patients to see how it worked
d) Put all patients on a spreadsheet to send them reminders