Content Focus: ED Return Visits

International Audit & Feedback Summit

LISA CALDER & LUCAS CHARTIER

MAY 4 2018

Introductions

- Please tell us:
  - Your background
  - What your connection is with audit & feedback
  - What are you seeking to learn from this workshop?

Goals & Learning Objectives

- Goals:
  - Share a KT story
  - Share one approach to motivating QI among frontline clinicians

- Learning objectives:
  - Facilitate peer to peer exchange on:
    - How to use A&F to address data gaps for clinicians
    - How to overcome common challenges
    - How to measure success

KT STORY

IT ALL STARTED WITH OBSERVATIONS IN CLINICAL WORK…

What is the problem?

- Patients return to the ED frequently
- Physicians don't always know:
  - Who returned
  - Why they returned
  - How to prevent avoidable returns due to quality issues

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- ***Pair & Share***
  - Knowing the above – how would you use audit and feedback to address these knowledge gaps?

What is the problem?

Why is this important?

- ED quality indicators are challenging
- Previous indicators limited
- No publications on e-triggers

But….patient safety is a major concern

Can an e-trigger efficiently identify adverse events among patients who RTED?

BMJ Quality & Safety Online First, published on 24 December 2014 as 10.1136/bmjqs-2014-003194

ORIGINAL RESEARCH

OPEN ACCESS

Adverse events in patients with return emergency department visits

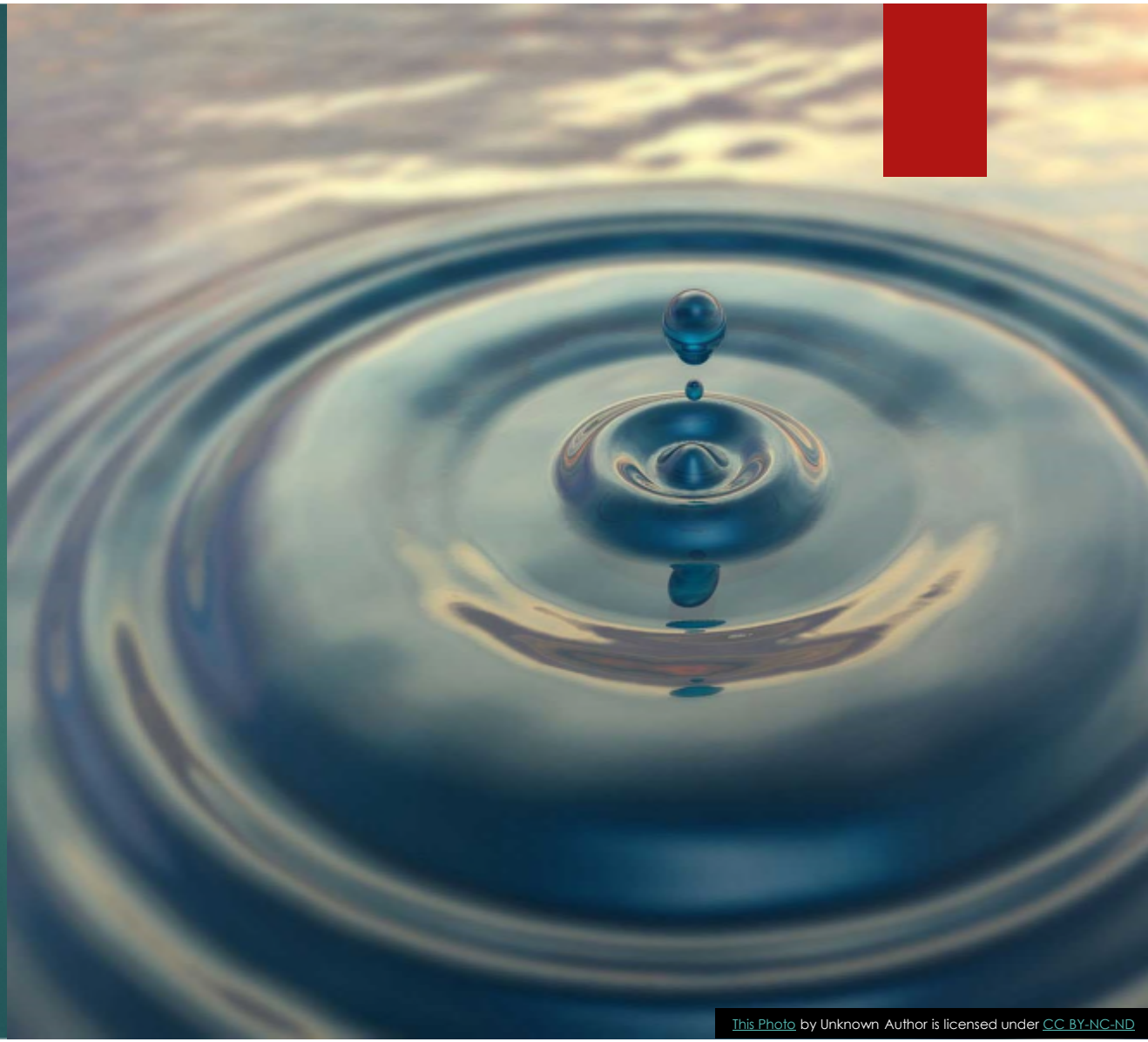
Lisa Calder,[1,2] Anita Pozgay,[1] Shena Riff,[3] David Rothwell,[2]
Erik Youngson,[2] Naghmeh Mojaverian,[2] Adam Cwinn,[1] Alan Forster[4]

How did we achieve our goals?

- Prospective cohort study
- E-trigger: RTED 7 days
- Nursing review: MD review
- AE determination
- Refined to:
  - 72h RTED → admission

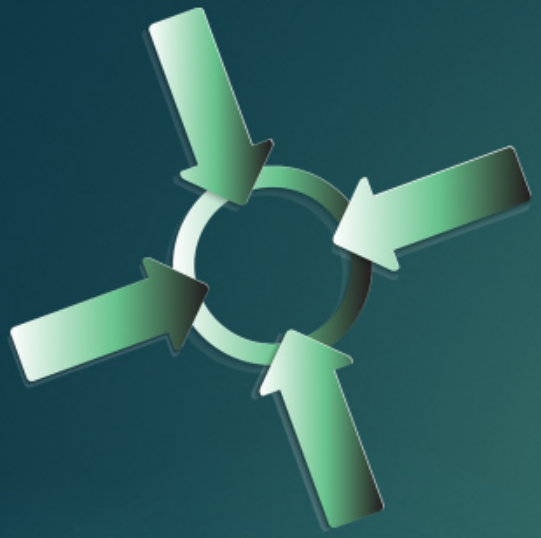
What were our results?

- 13,495 eligible visits,
  923 RTEDs within 7 days
  - PPV for AE 5.7%
  - with refinement, PPV 11.9%
- Preventability was just over 50%
- Need to examine 8 RTEDs to find one AE



EXCELLENCE IN CARE ACROSS ONTARIO
QUALITY IMPROVEMENT PLANS
QUORUM
QUALITY IMPROVEMENT IN ACTION
- ARTIC

Emergency Department Return Visit Quality Program

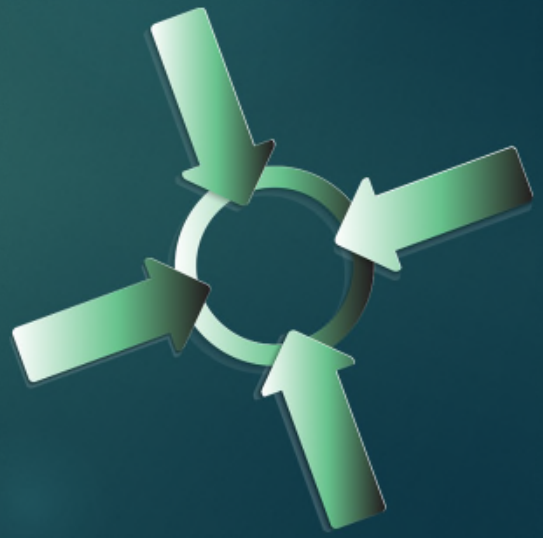


PROGRAM GOALS & COMPONENTS

HQO ED RETURN VISIT QUALITY PROGRAM

Program Goals

- Promote high quality ED care by helping clinicians & hospitals
  - identify, audit and investigate underlying causes of ED return visits
  - take steps to address these causes
  - Overall goal: prevent future return visits and harm

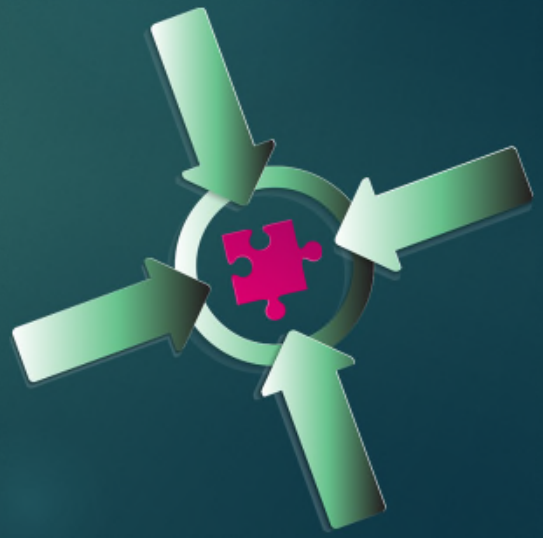


Program Components

- Tied to the pay for results (P4R) program
  - Component of the Emergency Room Wait Time Strategy
- HQO provided reports to all participating EDs with:
  - Number (%) RTED visits within 72h resulting in admission
  - Above for 3 sentinel diagnoses:
    - Acute myocardial infarction
    - Subarachnoid hemorrhage
    - Pediatric sepsis

Program Components

- EDs were mandated to:
  - Review a minimum of 25 RTED visits in year 1
  - Identify adverse events *or* cases with quality of care issues
  - Classify type and impact
  - Assess underlying cause
  - Identify areas for improvement
  - Submit a report to HQO



Program Development

- Literature review
- Expert panel
- Stakeholder engagement
- Development of audit tools and reporting templates

PROGRAM RESULTS

Program engagement

2016:

36,304 return visits within 72 hours resulting in admission were identified (of 3,672,708 visits analyzed)

This represents a return visit rate of **1.0%**

2017:

A total of **82** EDs submitted results for 2017

73 P4R EDs | **9** non-P4R EDs

84% of all ED visits in Ontario occur to these sites

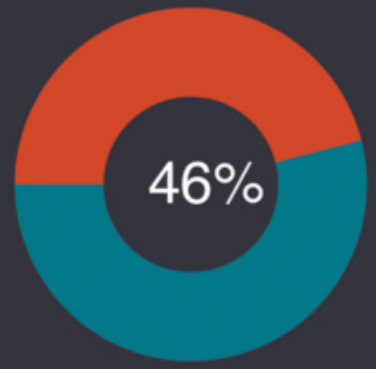
Audits performed, AEs identified

A total of **5015** audits were conducted

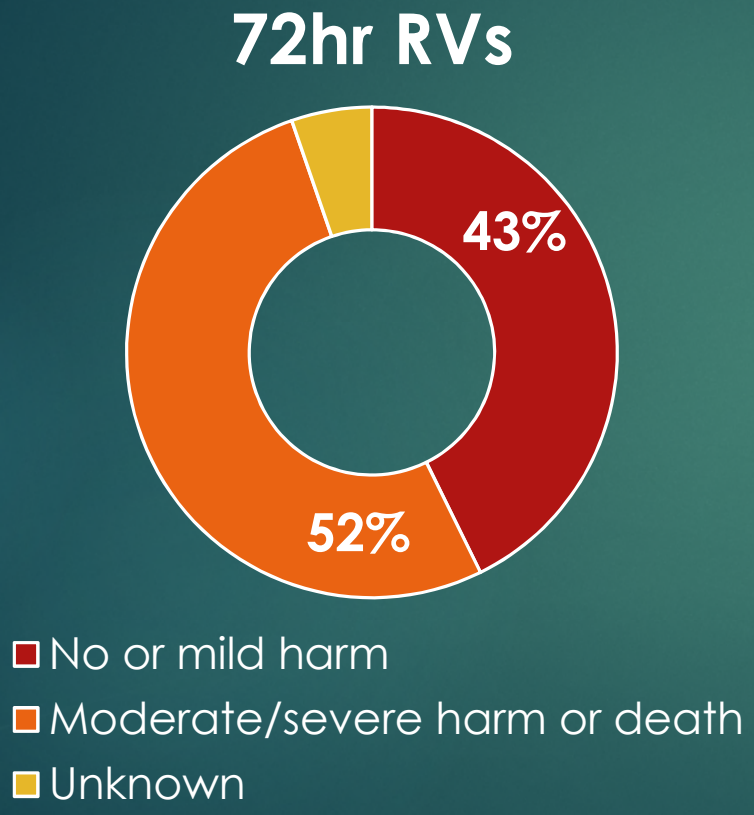
4711
all-cause 72-hour return visits

304
return visits involving sentinel diagnoses

representing rates of identification of quality issues/AEs of...

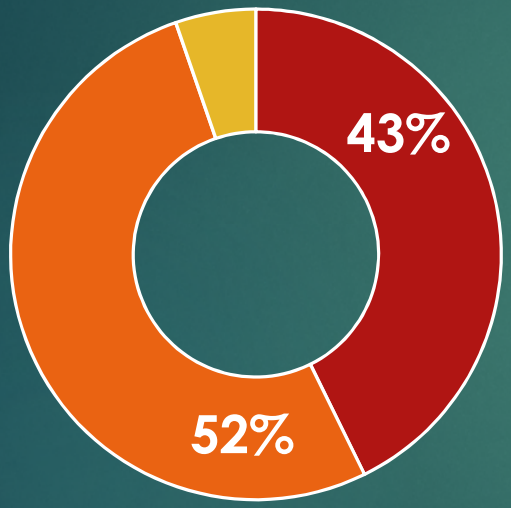


Severity of harm



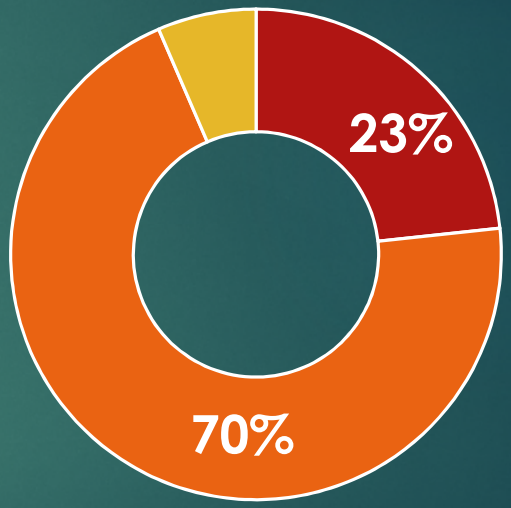
Severity of harm

72hr RVs



- No or mild harm
- Moderate/severe harm or death
- Unknown

Sentinel 7d RVs



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How to thematize adverse events?

Our first thoughts…

- Diagnostic issue
- Management issue
- Procedural complication
- Medication adverse event
- Unsafe disposition decision
- Suboptimal follow-up

…then with our analysis of 571 cases!

- Patient characteristics
- Actions or process of ED team
- System issues

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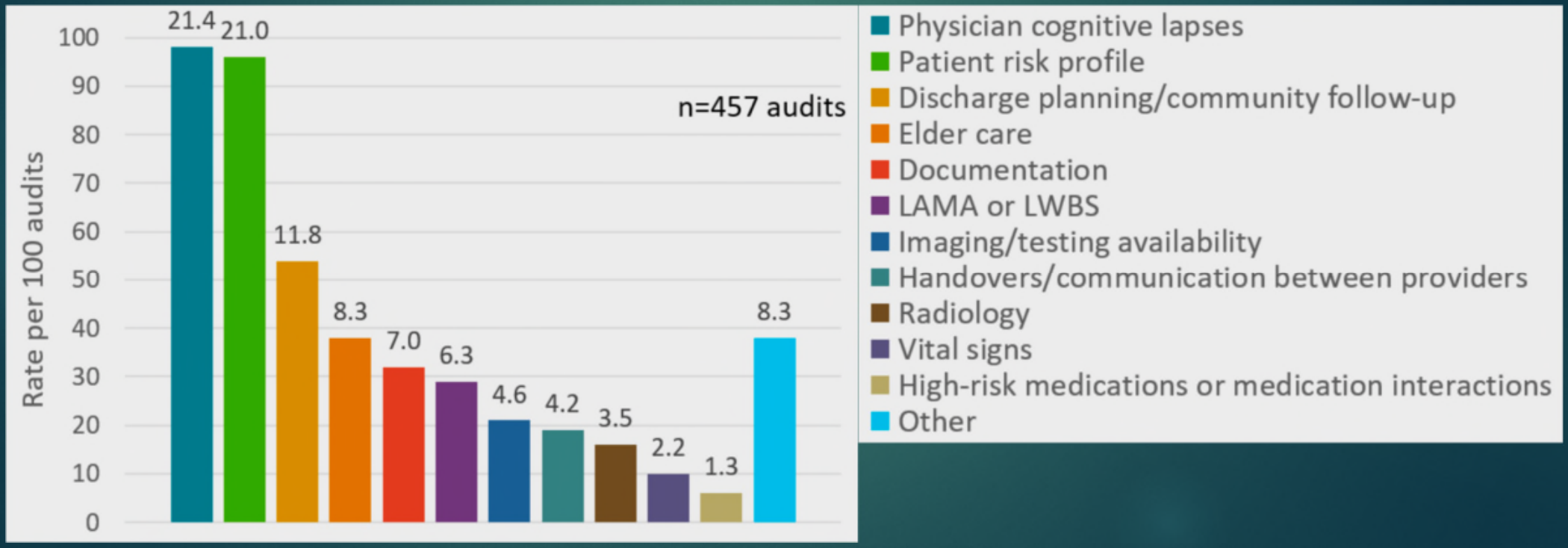
- Patient characteristics
  - Risk profiles, LWBS/LAMA
- Actions or process of ED team
  - Documentation, medications, handovers, radiology, vital signs, cognitive lapses
- System issues
  - Discharge planning, follow-up, test availability

Themes for adverse events



Program's impact at my sites*

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From problems…

…to solutions!

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- "Remember that patient…?" → Routine and non-threatening review

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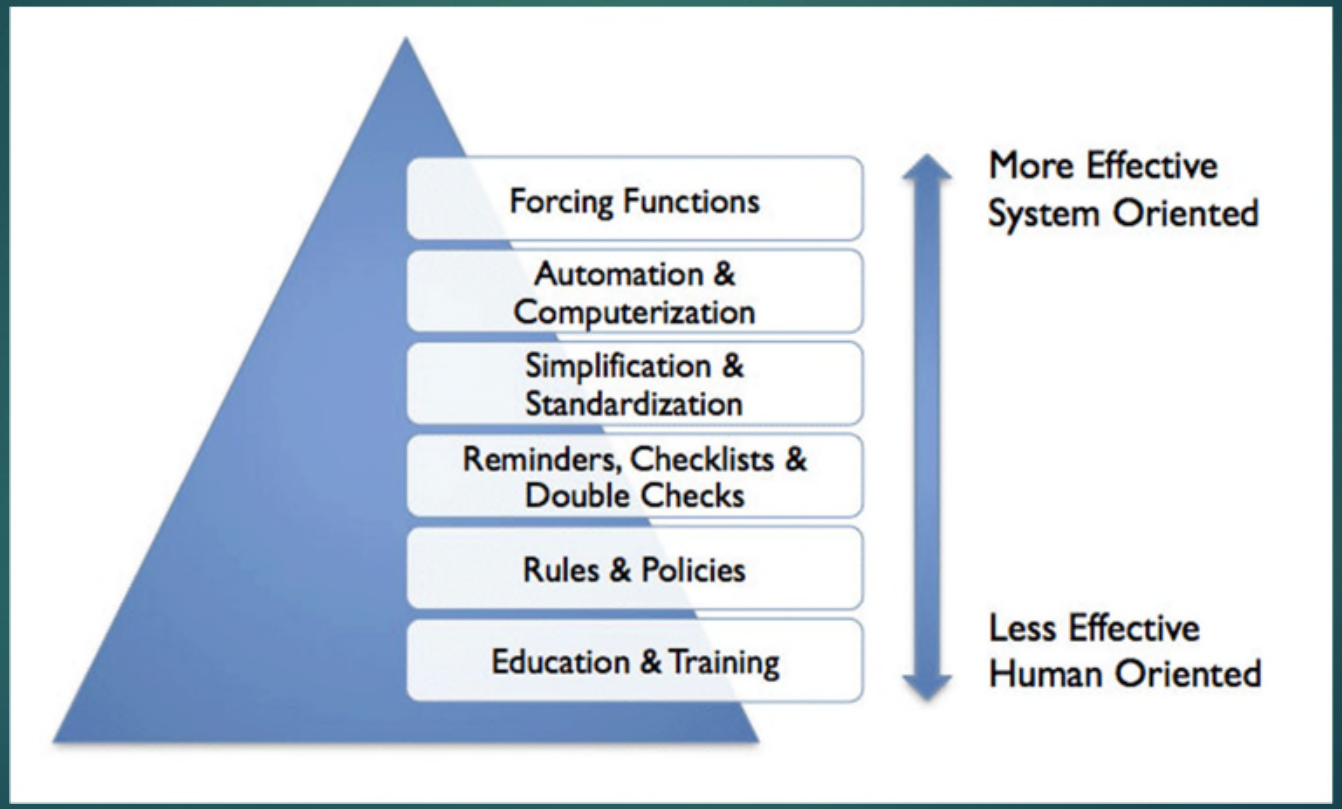
"Remember that patient…?"	→	Routine and non-threatening review
Retrospective review	→	Prospective outlook

Program's impact at my sites*

From problems…		…to solutions!
"Remember that patient…?"	→	Routine and non-threatening review
Retrospective review	→	Prospective outlook
Focus on people	→	Focus on system

Hierarchy of intervention effectiveness



Quotes from participants

- "Given the *nature* and intent of emergency care, the ED team often does not know post-discharge patient *outcome*. The program has allowed the opportunity to further analyze the *impact* of care on patient outcomes beyond the ED visit"
  - Scarborough & Rouge Hospital

Quotes from participants

- ”We have found that by including the *frontline* staff in this process, it allows for everyone to be part of the *learning* and the outcome, thus feeling invested in the *change* of the department”
  - Bluewater Health

Quotes from participants

- "The program fits well with our current post-adverse event quality review process, but has the added benefit that it is *proactive* rather than reactive to a reported adverse event"
  - North Bay Regional Health Center

Questions?

Small Group Exercise

Discuss at your table:

- Have you engaged in similar work of providing data to clinicians?
- What worked?
- What was challenging?

Small Group Exercise

Discuss at your table:

- In your experience, have clinicians been welcoming of data about their own practice?
- What made it more acceptable to them?

SUCCESS FACTORS

ITS ABOUT THE PEOPLE…PEOPLE

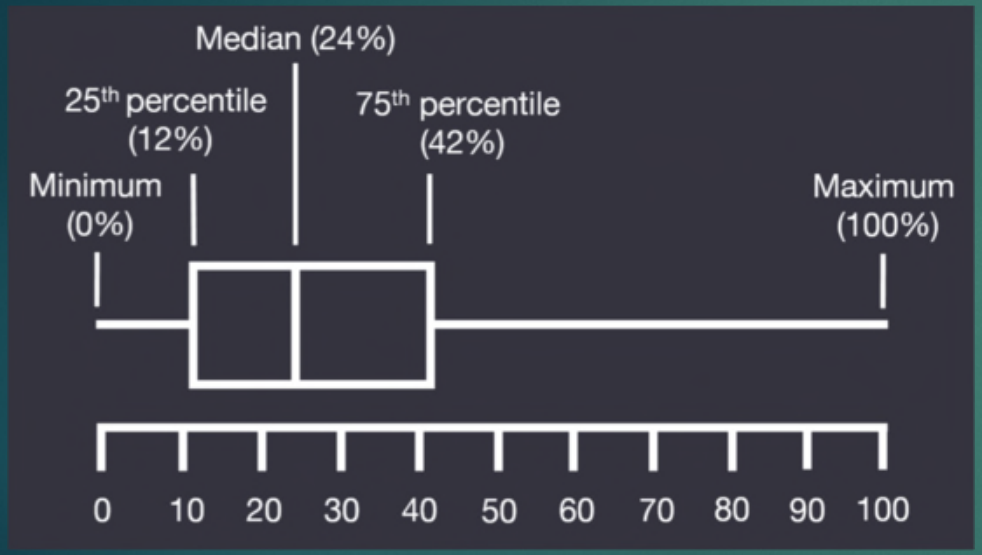
Success Factors

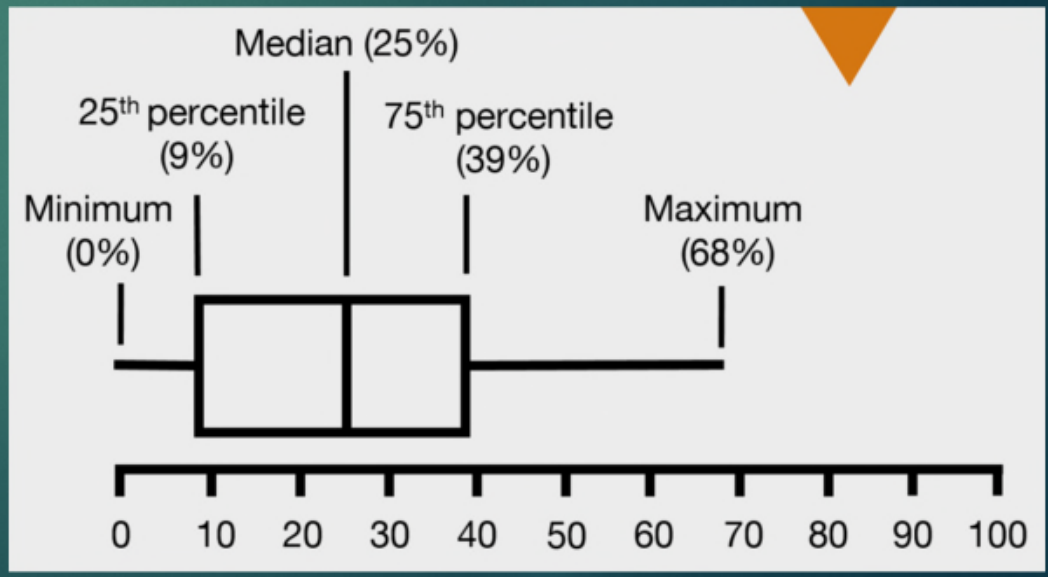
- Evidence based
- Diverse expert panel
- Engaged HQO team
- Resources to execute
- Flexibility to adapt
- Initial number of audits low and feasible
- Timing was right
- Data of great interest to clinicians

CHALLENGES

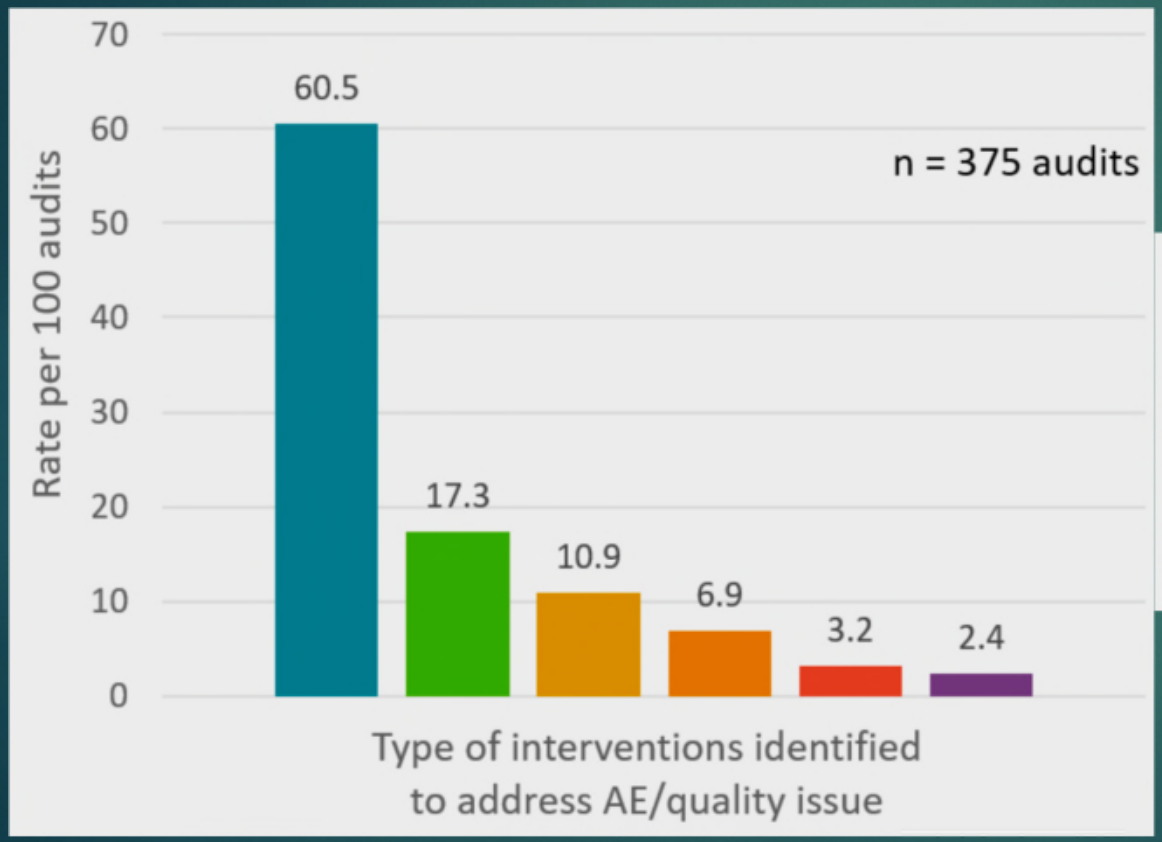
PROGRAM-WIDE HICCUPS AND LOCAL HEADACHES

What is an adverse event?





How do we address them?



Provincial challenges

- Engaging stakeholders in mandatory program
  - Planned qualitative evaluation
- Educating to build capacity
  - Webinar pending
- Facilitating collaboration
  - Yearly report

Local issues

- Buy-in
- Medico-legal concerns
- QI/system knowledge

Small Group Post-it Exercise

- Circulate to the pages on the wall
- Reflect on the question
- Write your responses on a post-it
- Then…post it!

Flipchart Questions for Post-it Exercise

- How do you motivate healthcare providers to learn from emotionally challenging cases?
- What are effective ways to standardize the measurement of adverse events region-wide?
- How do you measure the success of a mandatory audit and feedback program?

Questions?