

## Third National Primary Care Ambulatory Patient Safety Conference on Research and Education

On February 23 and 24, 2017, I had the pleasure of attending the “Third National Primary Care Ambulatory Patient Safety Conference on Research and Education” held in Bethesda, Maryland. The conference was sponsored by the Agency for Healthcare Research and Quality (AHRQ). AHRQ, a division of the United States Department of Health and Human Services, is the leading advocate and financial supporter of research and education promoting safer, higher quality healthcare in this country. The meeting brought together over 100 healthcare professionals from across the country, including physicians, nurses, physician assistants, pharmacists and trainees. While patient safety in the hospital (inpatient) setting has long been studied, it is notable that patient safety in the ambulatory (outpatient) setting is now coming to the forefront of national attention.

The presentations covered a broad spectrum of patient safety issues. I will focus my comments on the subject matter of the two plenary session speakers- [Dr. David Bates](#), Chief of the Division of Internal Medicine of Brigham and Women’s Medical Center and Medical Director of Clinical and Quality Analysis of Partners Healthcare; and [Dr. Nancy Elder](#), from the Department of Family and Community Medicine at the University of Cincinnati. Their presentations provided a broad overview of the present and future state of the field.

In his talk, “Ambulatory Patient Safety: A Global Perspective,” Dr. Bates emphasized the many safety challenges of primary care-including limited time with patients (the average outpatient visit is 12 minutes), frequent interruptions, and patients who frequently leave with unanswered questions. More specifically, he went into detail concerning what he perceived as the four key areas impacting patient safety in the ambulatory setting: follow-up post hospital discharge; medication safety; follow-up of abnormal tests; and ambulatory surgery. He provided extensive detail of the correlation of these safety issues and medical malpractice claims. He concluded by stating that while there is still lots to learn about safety outside the hospital, the magnitude of the problem appears to be as least as big as in the inpatient setting, with a key area being delayed and missed diagnoses, especially of cancer.

Dr. Elder spoke on “The EHR in Patient Safety and Medical Errors- The Good, The Bad, and The Ugly.” Her presentation on electronic health records was timely, given that the percent of office-based physicians using any EMR (electronic medical record)/EHR system at the end of 2015 was 86.9%.<sup>1</sup> She reviewed the initial hopes for EHRs, which included less paperwork, easy access to records allowing better care coordination, faster more accurate prescriptions, and fewer unnecessary tests and procedures, among others. The reality has been more complicated, with both

improvements and problems. The problem areas center on two main processes; entering and retrieving information, and communication and coordination. The process errors have impact across the clinical spectrum, including: 1) Medication and prescription errors-wrong drug/dose/formulation (juxtaposition errors from drop-down menus, rolling options lists “clicking” on unintended choices, auto-population errors where system suggests a drug from first few letters, which might be clicked inadvertently). 2) Testing errors-wrong tests ordered (for similar reasons as medication and prescription errors). 3) Diagnostic errors- resulting from problems of routing results between/among physicians and other providers, and decrease in use of letters/direct communication between physicians about patients because “it’s in the EHR.”

It is hoped that ambulatory safety issues will continue to receive this kind of attention as hospital lengths of stay decrease and procedures continue to shift to the outpatient setting.

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### **REFERENCES**

1. Centers for Disease Control and Prevention. National Center for Health Statistics. <https://www.cdc.gov/nchs/fastats/electronic-medical-records.htm>. Accessed April 17, 2017

