The Medical Office Survey on Patient Safety and the Culture of Your Medical Office

Lyle J. Fagnan, MD

If someone asked you to describe the culture of your medical office practice how would you respond? What attributes define the culture of your practice? Culture may be defined as “the way we do things around here” or the “the way we think about things around here” (Williams A 1994). A widely accepted definition of culture comes from the work of Edgar Schein — “The pattern of shared assumptions that the group learned as it solved its problems of external adaptation and internal integration, that has worked well enough to be considered valid and therefore, to be taught to new members as the correct way to perceive, think and feel in relation to those problems.”

The Medical Office Survey on Patient Safety (MOSOPS) is a tool to describe the culture of your medical office. The results of MOSOPS provide a way for you to begin the discussion of your office culture with the entire practice team. ORPRN led a national study of 300 primary care practices in the United States, involving 11 Practice-Based Research Networks (PBRNs). The PBRNs, including ORPRN, collaborated with Westat, a research organization that helped create MOSOPS and implemented pilot testing of the survey tool in 2007. In our study, over 9,000 members of primary care offices were surveyed across the United States. Thirty-six of the 300 practices were members of the Oregon Rural Practice-based Research Network.

One of the goals was to have a diversity of practices in an effort to provide a comparative database for the Agency of Healthcare Research and Quality (AHRQ) that is generalizable to a wide range of practice settings. We considered specialty, practice size, ownership, and health information technology capabilities in selecting practices for our study.

The 51-item survey captures a comprehensive snapshot of safety culture by measuring within 12 domains: 1) Communication Openness (4 items); 2) Communication About Error (4 items); 3) Information Exchange With Other Settings (4 items); 4) Office Processes and Standardization (4 items); 5) Organizational Learning (3 items); 6) Overall Perceptions of Patient Safety and Quality (4 items); 7) Owner/Managing Partner/Leadership Support for Patient Safety (4 items); 8) Patient Care Tracking/Follow up (4 items); 9) Patient Safety and Quality Issues (9 items); 10) Staff Training (3 items); 11) Teamwork (4 items); and, 12) Work Pressure and Pace (4 items).

The survey is on AHRQs website at http://www.ahrq.gov/qual/patientsafetyculture/mosurvindex.htm Examples of the report back to practices can be found at the ORPRN study website: http://www.ohsu.edu/orprn/SOPS/index.html

The characteristics of the 36 ORPRN practices participating in MOSOPS are informative. Medical office ownership included 39% physician owned, 36% hospital or health system owned and 22% government owned. The 800 survey respondents in these practices identified their staff position as 14.4% clinician, 8.5% nurse practitioner and physician assistant, 22% other clinical (primarily medical assistants), 8.8% management, and 31% administrative/clerical. Sixty-one percent (N=22) of the ORPRN practices are single specialty practices with 82% and 18% of these practices identified as family medicine and pediatrics. Fifty eight percent of the practices have fully implemented an EHR and 44% report electronic ordering of medications.

The 36 Oregon rural practices compared favorably with the national data. Figure 1 (see page 2) shows the overall percentage of positive responses across ORPRN as compared to the national sample.

Among the highlights of the results of the MOSOPS survey is the high rating most practices give to Teamwork. Questions in the Teamwork domain included: “When someone in this office gets really busy, others help;” “In this office, there is a good working relationship between staff and...”

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providers;” “In this office, we treat each other with respect;” and, “This office emphasizes teamwork in taking care of patients.”

The least positive rated domain was Work Pressure and Pace. Questions included: “In this office, we often feel rushed when taking care of patients;” “We have too many patients for the number of providers in this office;” “The amount of time we schedule for office visits is appropriate for effective patient care;” “We have enough staff to handle our patient load;” and “This office has too many patients to be able to handle everything effectively.”

There is a fair amount of variation in positive responses in most domains among the 36 ORPRN practices. Figure 2 refers to Work Pressure and Pace. Although the mean is 51% of positive responses, the range is from 18% to 90%. There is much to learn from practices where this domain is a major strength and those where this domain is a significant weakness.

MOSOPS has four main uses: 1) a diagnostic tool to assess the status of patient safety culture in a medical office; 2) an intervention to raise staff awareness about patient safety issues; 3) a mechanism to evaluate the impact of patient safety improvement initiatives; and, 4) a way to track changes in the patient safety culture over time.

Since we have shared the initial reports with our ORPRN practices, I have been impressed with the fact that most practices have not reviewed the MOSOPS results in detail and do not have a clear plan for sharing the results across the practice. This represents a missed opportunity to develop a practice culture that is influenced and informed by all members of the practice team. Nationally less than half of practices responding to a follow up survey report that they are planning a meeting with the clinicians and staff regarding their practices survey results. One clinician responding to our survey stated: “It (MOSOPS) is a great tool to reinforce the need for patient safety in the practice. I have broken up the survey and discussed sections at staff meetings.”

ORPRN is extending an offer to all 36 MOSOPS practices to facilitate a meeting of each practice’s clinicians and staff to review the results. We are sending out a one-page summary of each practice’s strengths and weaknesses as identified by the survey. This summary will accompany the full practice report. I am working with our regional Practice Enhancement and Research Coordinators to facilitate a practice meeting if requested. I have met with a few of the practices during the past few months and will make meeting with our MOSOPS practices a priority.
Harry Rinehart, MD, featured in *1859 Oregon’s Magazine*

Named for Oregon’s year of statehood, the Spring issue of *1859 Oregon’s Magazine* profiled “three extraordinary medical practices that care for people regardless of their ability to pay.” Harry Rinehart, MD, and the Rinehart Clinic are featured in the article, “Strong Medicine.” Included is a history of the practice (he’s a third generation doctor in Tillamook County) which led to it becoming a Federally Qualified Health Center in 2008.


Harry Rinehart, MD, wins 2010 ORPRN Research Ideas contest

Harry Rinehart, MD, of Wheeler, submitted the winning research ideas at the OAFP/ORPRN Annual Spring CME Weekend May 6-8 in Portland. ORPRN’s steering committee voted on the ideas submitted and Dr. Rinehart won both first and second place (and tied with himself for second place). Dr. Rinehart received gift certificates to Powell’s Books.

At the conference, research ideas were collected at the ORPRN exhibit table from all conference attendees. The submissions include the following: “Please describe a problem, practice issue, or gap in knowledge that you encounter in clinical practices or think is common in rural primary care that research could address” and the additional “If you have any ideas about a research design, please describe a possible study that ORPRN might conduct to address the research question.”

First place research idea:

1. Would distribution of a Shared Decision Aid (DA) increase Oregon’s low immunization rates? Develop the DA and check immunization rates before and after distribution.

Second place was tied, with both research ideas from Dr. Rinehart:

2. For diabetics in rural Oregon who are not getting annual eye exams, would a retinal camera and partnership with an ophthalmologist at OHSU provide the needed care? Track exam rate changes and outcomes, and select a percentage of patients to have clinical eye exams. Compare those to the camera findings.

3. Would hiring “patient care coordinators” from the community and training them as Medical Assistants while on the job provide a reasonable level of assistance to providers and patients in an ambulatory care setting? Develop a training for this purpose and create a way to rate performance. This question arose out of the prohibitive expense of hiring an RN in a small rural practice.

Welcome Sean Benson, DDS

ORPRN joins the Practice-based Research in Oral Health Network (PROH) in welcoming Sean Benson, DDS, to the PROH steering committee. Dr. Benson practiced in La Grande for three years before moving to Baker City. He received his doctor of dental surgery degree from Ohio State University. Dr. Benson was quoted in the PROH newsletter as saying he joined the PROH network because “it is a very practical and necessary evolution of research. It is critical for the practical applications of evidence-based dentistry.” He credited Tom Hilton, DMD, MS, PROH’s director, and Jon Schott, MD, as influencing his decision to participate in practice-based research.
The Oregon Trail

It is hard not to be energized by what is happening in Oregon.

I was privileged to be able to attend meetings last month at the two Eastern Oregon sites – Pioneer Medical in Heppner and Winding Waters in Enterprise. I was struck by the rural nature of these two clinics, where both communities are ~30 miles to the highway then another dozen or so miles to a larger town. The remote location of both of these clinics adds an interesting twist to the implementation process.

The Practice Enhancement Research Coordinators (PERCS) from ORPRN are literally the “Pony Express” – delivering guidance and management of the project across a stunningly beautiful yet rural terrain. Cows definitely outnumber people in Eastern Oregon I think!

The population of Heppner and the surrounding area is ~1500 and there are 6 family practice physicians serving the community along with one PA. The clinic has all the makings of a model site – there is engagement in shared decision making across all roles in the clinic with physician champion Betsy Anderson leading the charge. They are currently implementing Diabetes, CAD and Chronic Pain DAs and have an amazing 96% survey return rate. When I asked the practice PA Sheridan Tarnasky how they achieved such high numbers she explained that follow up calls are made at 2 week intervals post distribution to encourage viewing and answer questions. She also mentioned that they know where everyone lives! Closing the loop happens at a subsequent visit which works well for diabetes patients who have regular visits to the clinic. The grant has allowed the practice to hire a part-time nurse to oversee the distribution of DAs, return of survey data and tracking of process measures. During our site visit the clinic staff chatted about how to best engage the community in the project and the hospital CEO was in attendance and pledged continued support of the project. The staff at Pioneer Medical is excited and engaged about the implementation of shared decision making and decision aids across the practice and this was a real boost to my spirit!

Winding Waters in Enterprise (population ~1700) had an in-service the next morning to discuss the project and brainstorm how to increase distribution and effectively close the loop with patients and providers. It was exciting to hear Dr. Powers and Dr. Grandi encourage the staff to think of creative ways how to identify and target appropriate patients for the decision aids. DA/SDM “boxes” have been developed and are placed in each exam room so providers can easily grab a DA, explain the process and endorse the DA during a warm hand off. The small step of transcribing the ID from the packet to the log page had the potential to derail the process until it was decided that a small sticker placed on the packet could be placed in the log and no transcription was needed. This tiny step, which seemed like a big problem, was solved with a sticker and some ingenuity.

These visits were Melinda’s “swan song” as she joins the research ranks at ORPRN in Portland and leaves her beloved Eastern Oregon behind. Jill Currey, a sassy Texan and recent grad from Pennsylvania will take her place as the Eastern Oregon PERC. The sites will miss Melinda’s presence but welcomed Jill with true warmth. She’ll be a tremendous asset to the implementation projects in Oregon.

I dare you not to be energized by what is happening in Oregon.
Incorporating Decision Aids in Rural Primary Care – highlights from a tour of Oregon

ORPRN is participating in a 3 year project supported by the Boston based Foundation for Informed Medical Decision Making (FIMDM) to learn how to incorporate Decision Aids (DAs) into primary care practice and to evaluate their efficacy [http://www.informedmedicaldecisions.org/]. FIMDM representatives traveled to the four ORPRN demonstration sites: Pioneer Memorial Clinic in Heppner, Winding Waters Clinic in Enterprise, Bayshore Family Medicine in Pacific City and Lincoln City Medical Center in Lincoln City. Practice staff and clinicians shared the processes they used to select priority DAs from over 30 available topics, described their streamlined approaches for patient identification, DA distribution and follow-up, and identified strategies to support the spread of DAs clinic wide. Clinics were able to ask questions about DA content, revisions, and FIMDM priorities.

Since January, the four clinics have distributed over 160 DAs to patients on topics such as Managing Menopause, Weight Loss Surgery: Is it Right for You, and Living with Diabetes: Making Lifestyle Changes. The ORPRN Shared Decision Making project, along with 11 other FIMDM primary care demonstration sites, is providing a roadmap for approaches to integrate shared decision making into routine primary care practice. ORPRN is currently recruiting two additional practices to engage in this project. Please contact your PERC for additional details.

Nurse Care Manager study success is reported in Care Management Plus Newsletter

The July-September 2010 newsletter CM+ included a report from Eastern Oregon Medical Associates (EOMA) in Baker City. Congratulations to Mary Stearns, RN, and the support team!

Care Manager Success Story

“Dr X. referred an elderly woman to me. Her daughters, who do not live in the area, spoke with her over the holidays and she told them she had stopped all her medications because she couldn’t afford them. This was not accurate (she can afford but had not taken any meds for about 2 wks) and the daughters knew something was not right so they came into town and took her to see Dr X. Patient was confused, and MMSE score was below normal. Patient was unable to manage her medications and it was questionable if she could stay in her home due to this significant dementia. We came up with a plan using community resources, daughters, care manager, physician, etc. to ensure proper med administration, consistent twice daily check-ins, meal monitoring. Thus far, patient is succeeding in her home. She has lunch at our senior center Mon through Fri (and has the bus pick her up for this), she pays a caregiver to set up med pill box, and they visit every evening to make sure she has taken am and pm meds. She also does some meal prep and visits with patient. She sees me now about once a month. This past month she improved slightly on her MMSE. She is so happy to stay in her home!!!”

- Mary, EOMA, OR
The assets right in front of you

Paul McGinnis, MPA

The lead article in this issue is focused on the Medical Office Survey on Patient Safety (MOSOPS). Given there are four to six full time equivalent staff for every clinician in a primary care practice, their responses dominate the outcome of the survey. Good or bad, your staff’s perceptions paint a picture of the safety culture of the practice. The staff’s attitudes and perceptions of everything that goes on effects all that occurs within your clinic. Throughout this article are some quotes from respondents of the MOSOPS that illustrate common themes.

Attention is being paid to how those relationships affect your clinical and financial success. Studies indicate that successful practices have functional work relationships.¹ Seven interdependent characteristics of work relationships were observed in those successful practices. They included Trust, Diversity, Mindfulness, Interrelatedness, Respect, Varied Interaction and Effective Communication. The article defines these terms. A physician reported that, “patient safety and quality of care could be much improved if there was better communication between staff and providers and if all staff and providers felt able to recommend and try changes.” To accomplish this, these work relationships must be developed.

Another study concludes that building strong relationships among physicians and staff improves the practice’s ability to deal with uncertainties of a rapidly changing environment.² Change is constant and the rural clinic environment is not exempt from the demands health reform at the national level will bring.

Increasing your staff’s job satisfaction level will help build relationships that produce high functioning teams. In a survey of 1,000 employees and 100 of their bosses, subjects were asked to list things they believe motivate employees. The bosses thought “good wages” and “job security” were most important. Their employees listed “participation,” “feeling appreciated,” and “being in on things.”³ A survey respondent said, “We (staff) do want to improve systems.” The way to achieve this is by asking questions of them, listening respectfully and engaging them in deciding how changes in the practice can be implemented. Staff wants to be involved BEFORE rather than AFTER decisions are made. A nurse said “staff does not always feel consulted or communicated with or appreciated by upper management. This relates to quality of care only as it relates to morale and self esteem of staff.” Staff turnover slows down production and impacts quality of care. A suggested measure of staff turnover is 15 percent or less in the last five years.⁴ The causes of turnover include job dissatisfaction due to inflexible schedules, a lack of professional development, burnout, and a lack of collaborative processes around clinical and practice issues.

If the results of the MOSOPS were pleasantly surprising to you; can you identify specifically what you have intentionally done to positively build your practice culture? If so, do more of it. If the results were disappointing, begin the change process with an open and honest discussion among your staff. But, you as leader must truly want the input, actively listen to what they say and convince the staff that your motivation is providing the best patient care possible. As one nurse said “I don’t feel we can say anything without retribution, it is negative. Only positive comments are allowed.” Sometimes it is good to have an outside facilitator help with this initial discussion. Should you want that, contact ORPRN.

¹ Tallia A, et al, 7 Characteristics of Successful Work Relationships, Family Practice Management, January 2006
⁴ Capko J. Identifying the Causes of Staff Turnover, Family Practice Management, April 2001
Elizabeth Powers, MD

Elizabeth (Liz) Powers, MD, is a family physician at Winding Waters Clinic in Enterprise. A rural Michigan native, Liz attended medical school at Stanford and completed her residency here in Oregon at OHSU Family Medicine. Liz has described her involvement in ORPRN as a “happy accident” as Winding Waters has been an active ORPRN member since she first came on board as a resident. Dr. Powers’ ongoing passion for academic and research pursuits have been a great asset to ORPRN in encouraging practice-based research and real world application to the communities she serves. As a Steering Committee member, Liz continues to serve as an advocate for change. She believes in her clinic’s future with ORPRN, not only as a catalyst to push her clinic towards what it means to practice patient-centered medical care, but as a champion for future practice-based research. We are looking forward to many future “happy accidents” with Dr. Powers and her family.

Dr. Powers was quoted on a recent posting to the Foundation for Informed Medical Decision Making blog, saying, “As physicians we’re trained to diagnose illnesses but not to diagnose patient preferences.” Her statement led a section entitled “Introducing the Patient Experience Project” and she was cited as being a Decision Making Champion.

Welcome to ORPRN

Jill Currey received her MPH from the University of Pittsburgh and has experience in clinical and community-based research. At the University of Pittsburgh Medical Center, her work focused on the social behaviors of aging and on cardiovascular functioning in women. Jill also worked at the Mayo Clinic in Rochester, MN, on a study involving radiation treatments for breast cancer and Hodgkin’s/Non-Hodgkin’s lymphoma. She received her BA in Sociology, Chemistry and French from Baylor University in Waco, Texas. Originally from Corpus Christi, TX, Jill is an avid traveler and is excited about the opportunity to experience all that Oregon has to offer. Jill serves the Northeast Oregon Practice Enhancement Research Coordinator and her office is located on the Eastern Oregon University campus in La Grande.

Molly DeSordi is a Practice Enhancement Research Assistant serving the Cascades East region. Molly will work in tandem with Christine Toomey to serve this region. Molly is a Crook County High School graduate who will work to build a community of clinical practices and community resources in Central and Southern Oregon. She graduated from the University of Oregon with a degree in both human physiology and psychology with a minor in chemistry. While at U of O, she worked as a research assistant in the Social Cognition Laboratory, where she conducted research projects for dissertation research of doctoral students.

Sonya Howk is a research assistant with ORPRN, where she coordinates data collection, creates study databases, works with the PERCs, and coordinates contact with clinics. She has a BA in Political Science from University of Oregon, and a Masters in Public Administration with an emphasis in Healthcare Administration from Portland State University. Sonya has worked at OHSU for 10 years. At the Oregon Office of Rural Health, she was an Information Coordinator, and most recently she was the Fellowship Program Coordinator for the Department of OB/Gyn. Sonya is excited to join a team promoting health research in partnership with rural health clinics.

Michelle Thomas is the Practice Enhancement Research Coordinator for the Oregon Pacific region, with an office in Lincoln City. She worked for the past 29 years at the University of California at Irvine Medical Center in Orange County, CA. As a Licensed Clinical Social Worker, she began her career in the Department of Psychiatry. She spent several years working in clinical trials in the Inpatient Research Unit, later working in community recruiting and screening of patients for studies. She later worked on medical/surgical units, oncology inpatient/outpatient areas, as well as covering adult/pediatric units, the Emergency Department, and Intensive Care units. Michelle retired in 2008 as the Chief Clinical Social Worker. She and her husband moved to Gleneden Beach.

Chris Toomey was born and raised in Dufur, OR, on land homesteaded by her family. She got her BSN at U of O School of Nursing in Portland and continued her career at OHSU, working in Labor and Delivery. She gained experience in research while doing an ante-natal fetal monitoring trial using some of the newest technologies. When Dr. Leon Speroff, former OB/GYN Dept. Chairman returned to OHSU he was able to create the Women’s Health Research Unit and Chris and another RN were responsible for all aspects of clinical trials in all areas of women’s health. Chris retired with her husband to 120 acres on a hay and cattle farm in Madras, OR where she enjoys the outdoors. She is very excited to return to OHSU and research again, this time in the rural setting which she loves. She will work in tandem with Molly DeSordi as a Practice Enhancement Research Coordinator in the Cascades East Region.
Publications


Findholt NE, Michael Y, Davis M, Broggiotti VW. (in press, Fall 2010). Environmental Influences on Children’s Physical Activity and Diets in Rural Oregon: Results of a Youth Photovoice Project. The Online Journal of Rural Nursing and Health Care. 10(2).


OAFP/ORPRN Annual Spring CME Weekend

ORPRN partnered with the Oregon Academy of Family Physicians (OAFP) for their 63rd Scientific Assembly and Congress. Twenty-nine ORPRN member clinicians joined the 139 registrants at the Embassy Suites Downtown Portland on May 6-8, 2010. ORPRN’s afternoon of sessions, entitled “The Patient Centered Medical Home (PCMH) -- Facilitating Practice Change Through ORPRN Research” was introduced by Robbie Law, MD, of Reedsport. Member clinicians Bruin Rugge, MD, MPH, from Scappoose and Liz Powers, MD, from Enterprise teamed up to present their achievements and challenges during the first year or implementing the PCMH in Safety Net Clinics. On a panel led by LJ Fagnan, MD, Sandra Dunbrasky, MD, from Ontario, Esteban Miller, MD, from Klamath Falls, Carla McKelvey, MD, from Coos Bay, and Jon Schott, MD, from Baker City, shared their experiences working with a nurse care model to improve care of patients with a chronic condition. ORPRN’s LJ Fagnan, MD, presented a session on the results of the Medical Office Survey on Patient Safety, Melinda Davis, PhD, and Valerie King, MD, presented on the Shared Decision Making study, and Paul McGinnis, MPA, facilitated a discussion regarding the results of ORPRN studies and how they fit Patient Centered Medical Home experiences of the audience.

The OAFP/ORPRN Spring CME will be held at Skamania Lodge. Mark your calendars now for April 7-9, 2011.

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Janet Patin, MD, Reedsport, proudly wears the ORPRN tattoo at the OAFP/ORPRN Spring CME.