Final Report

Patient Safety: Physician Assistant Responsibilities and Opportunities

An educational conference program of the

American Academy of Physician Assistants

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The American Academy of Physician Assistants (AAPA) is the national professional association for all physician assistants practicing in all specialty areas and in all practice settings. There are currently 68,000 PAs in clinical practice in the US as well as 10,000 PAs in training.

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Structured Abstract

Purpose: The Patient Safety: Physician Assistant Responsibilities and Opportunities conference program endeavored to advance the awareness, knowledge, and leadership of PAs in patient safety. The program was created to reach all 40,000+ AAPA members to some degree with information on patient safety challenges, strategies to improve patient safety in their particular specialty and setting, and opportunities to take a leadership role in patient safety. The AAPA Quality Care Committee (QCC) reviewed patient safety resources and consulted with experts to identify applicable lessons. The QCC recruited PA organization and practice leaders to the conference program to determine the specific needs of PAs in their state or specialty with respect to patient safety and health system interventions. A representative sample of PAs from all clinical specialties was surveyed to identify current attitudes toward patient safety and related issues. Almost 1,000 PAs from eight states participated in the case-based and customized conference education program. In addition, key patient safety issues and lessons identified through the conference program were disseminated to all AAPA members through a series of articles in the biweekly AAPA News as well as a series of patient safety CME lectures to be delivered at the 2007 Annual PA Conference. The patient safety conference program reached thousands of PAs with information on the critical importance of patient safety as well as proven means to improve safety in their setting. The program also generated development of a safety program for the 10,000 PA students in training.

Key Words: safety, patient safety, physician assistants, PA

Purpose:

The challenges of preventing medical errors and improving patient safety have received substantial attention during the past 10 years. Physician assistants are an important and growing audience for patient safety advocates and are important leaders in advocating for patient safety and in helping to change institutional culture for safety. However, no information has been published as to the attitudes, knowledge, and skills of physician assistants about patient safety. There are now about 68,000 PAs in clinical practice providing patient care in all clinical settings and in all medical and surgical specialties when physicians normally provide care. PA competency with effective patient safety practices and tools will improve the quality of patient care and lead to better patient outcomes.

The diverse models of PA practice meant that no set group of errors or collection of safety improvements would apply to all PAs. The Quality Care Committee of the AAPA, composed of PAs active in patient safety initiatives at the practice, institution, and system levels, sought a small conference grant in order to provide all PAs with patient safety information relevant to their setting and tools they could utilize immediately. The QCC needed to assess the safety issues present in PA practice, identify effective safety improvement strategies, and disseminate this information to as many PAs as possible. In addition, QCC sought to persuade PAs to take a more active leadership role in addressing patient safety in their practice or institution.

The four primary objectives of the conference program were:

1. PAs will gain awareness of patient safety issues and the availability of system strategies to improve patient safety
2. PAs will receive knowledge of current research findings in patient safety and ways to develop and implement system interventions
3. PAs will learn how to change their behavior as well as initiate changes in their clinical setting
4. PAs will be taught tools to be leaders in changing the culture of healthcare.

Scope:
The scope and seriousness of patient safety is well established. The national dialogue around medical errors and patient safety was prompted by publications such as the 1999 publication of the Institute of Medicine report, "To Err Is Human." This was followed up by another IOM report called "Crossing the Quality Chasm." These were followed by other reports like the "Wall of Silence." The GAO has reported that deaths due to medical errors in the US are greater than other certain causes of death, such as automobile accidents, breast cancer, and AIDS. Medical mistakes cause almost 100,000 deaths and 1,000,000 injuries every year in this country.

The approximately 68,000 PAs in clinical practice provide patient care in all medical and surgical specialties, practicing in physician-PA teams to help ensure access to high-quality patient care. PAs are responsible for well over 300 million patient encounters annually. They perform invasive procedures, write millions of prescriptions (Level II-VI medications), and recommend numerous other treatments. PAs occupy a very central position in the network of healthcare professionals caring for patients, working with physicians, nurses, pharmacists, therapists, various technologists, and many others. The vast amount of patient care in which PAs are involved means that all PAs must be active and accountable participants in patient safety and quality improvement processes.

The AAPA House of Delegates reaffirmed its policy in 2005 stating that health professionals and organizations should improve the quality of healthcare in the US by:

1. Supporting patient safety efforts
2. Reducing medical errors
3. Promoting evidence-based care
4. Encouraging communication among members of the healthcare team, and
5. Emphasizing the team approach to healthcare

Also in 2005, at AAPA's Annual PA Conference, patient safety experts from AHRQ and the Veterans Administration held a workshop on human factors in patient safety. This success of this activity and the value of the information to all PAs led to support for much greater dissemination of patient safety information to the entire PA profession.

It is with this background the QCC of the AAPA carried out the Patient Safety: Physician Assistant Responsibilities and Opportunities conference education program.

Methods:

The safety conference program consisted of several overlapping stages:
Background and pilot program: Dr. Crane, the QCC, AAPA staff advisors, and several external safety experts consultants researched and discussed the most information on patient safety with respect to care settings, clinical areas, types of errors, safety targets, and various interventions to improve safety. That work resulted a panel presentation delivered at the AAPA Annual PA Conference in May 2006. The session used a virtual patient's series of interactions with the healthcare system to demonstrate errors in medications, technology, and information. Lessons from ambulatory, ED, inpatient, and radiology settings were incorporated. Recommendations for system interventions to prevent future errors were discussed. Significant time was dedicated to attendee participation, questions, and suggestions in order to identify patient safety information of greatest value to PAs. This feedback was incorporated into development of the final patient safety conference education program.

PA Community assessment: In conjunction with delivery of the pilot educational session, the QCC received 200 completed surveys from PA organizational leaders, representing PAs from all states and specialty areas. The 20-question survey was anonymous and was an adaptation of a survey administered to medical students at the University of Colorado. The questions asked PAs to rate their agreement or comfort with the statements on a five-point Likert scale. The survey provided insight into the knowledge, attitudes, and skills of PAs on patient safety and medical errors. Results from the survey helped to determine the focus of subsequent conference program activities, such as educational sessions delivered at constituent organization conference and PA publication articles.

Dissemination: Dissemination of information to members of the PA profession occurred through two primary channels: conference education sessions and PA publication articles. A conference education session was developed and delivered to almost 1,000 PAs at eight PA state and specialty organizations. As the practice demographics in various groups differed slightly, the conference presentation was customized to best serve the needs of the PA attendees. A selected member of the QCC led presentation and discussion. The PAs involved were members of The New York State Society of PAs, the Minnesota Academy of PAs, the Michigan Academy of PAs, the Tennessee Academy of PAs, the Colorado Academy of PAs, the Association of PAs in Cardiovascular Surgery, the Upstate Medical Center NP/PA Grand Rounds, and the Florida Academy of PAs.

Presentations and discussions included, but were not limited to:

- Care settings: ambulatory clinic, inpatient unit, ambulatory surgical center, inpatient surgical department, and academic vs. nonacademic medical center
- Clinical areas: primary care, anesthesiology, critical care, emergency medicine, obstetrics, pathology/lab, pediatrics, radiology, surgery, and pharmacy
- Types of errors: both active errors and latent errors

- Safety targets: medication prescribing, patient identification, communication/hand-off, surgical complications, medical complications, health information technology
- Interventions to improve safety: communication improvement, teamwork training, human factors engineering, information technology, multiple quality improvement strategies, and the culture of safety

QCC worked with the editors of the biweekly AAPA News to identify important patient safety information and stories in order to better inform the entire AAPA membership about patient safety issues. Articles focused on specific safety interventions as well as improving the culture of safety in a practice or institution.

Assessment: Assessment of the utility and value of the patient safety conference education program was continuous throughout the project. Additional assessment of the QCC patient safety conference education program is currently being completed. The AAPA Annual Conference Survey to be administered in May 2007 will asses the typically 5,000 respondents on their knowledge of patient safety, use of effective patient safety practices, additional safety information needs, and confidence in affecting positive cultural change.

Results:

Surveys and conference discussions yielded information about PA attitudes, knowledge, and skills that are serving to guide current and future patient safety activities among PAs.

The 2006 organization leadership survey showed that PAs strongly agreed that professional time should be spent on improving patient care and learning how to prevent errors. PAs also agreed that making errors in medicine is inevitable. PAs were netural, on average, about whether they routinely report medical errors or whether they routinely share information about errors and their causes. PAs strongly disagreed that only errors that harm patients need to be addressed and that only incompetent PAs make errors. When asked about their comfort level with an error prevention activity, PAs were comfortable with supporting and advising a peer on how to respond to an error and with analyzing a case to find the cause of an error. PAs were less comfortable with entering a Patient Safety Net report and with disclosing an error to a patient.

Discussion among various conference participants yielded important comments and observations. Many PAs felt that patient safety was not discussed frequently enough in their practice or institution. Others reported that patient safety was not considered a scientific pursuit, and therefore, advances in patient safety were not given as high a priority as advances in pharmaceutical or surgical treatments. Importantly, most PAs felt a critical aspect of improved patient safety and higher-quality care is a patient-centered, team approach to care.

The Patient Safety: Physician Assistant Responsibilities and Opportunities educational conference program has resulted in several additional activities undertaken and supported by AAPA.

- Results from the 2007 Annual Conference Survey will be available by the end of July.
- The QCC has worked with the AAPA Conference Education Program Committee to dedicate four CME sessions to patient safety issues at the 2007 AAPA Annual PA Conference.
- Several educational sessions at the 2008 AAPA Annual PA Conference will focus on the unique risks and benefits of health information technology on patient safety.
- The QCC patient safety conference session will be distilled into an article for publication in the Journal of the American Academy of Physician Assistants, the official peer-reviewed journal of the AAPA, with distribution to almost 65,000 PAs.
- The QCC has submitted a proposal to the Physician Assistant Education Association (PAEA) to offer a 1-day train-the-trainer workshop to PA faculty on patient safety. PAEA is an association of all 137 accredited PA education program in the US. This workshop will be offered as an adjunct to PAEA's annual meeting during their Faculty Development Institute. Lectures, small-group activities, and curriculum development activities will provide attendees with the background and information on patient safety that they could incorporate into their curriculum. Emphasis will be given on how to develop an interdisciplinary patient safety training curriculum at their institution. Substantial supportive resources will be provided to faculty attendees, including model curricula, experts in the field (including those from AHRQ), and web-based resources. The workshop will be able to accommodate up to 50 PA faculty. The proposal has been accepted for the PAEA midyear meeting in May 2008.

List of Publications and Products

Professional News Articles

- Doscher C. 122,300 Deaths Avoided, Report States. *AAPA News* 2006 July 15; 1.
- Doscher C. Prevention Strategies, Communication with Patients Can Reduce Errors. *AAPA News* 2006 Aug 30; 1.
- Doscher C. FDA Targets Dangerous Abbreviations. *AAPA News* 2006 Aug 30; 10.
- Doscher C. Acknowledgement of Errors Can Improve Culture of Safety. *AAPA News* 2006 Oct 15; 4.
- Kuttler H. In Hospital or Small Practice, Patient Safety is Key. *AAPA News* 2006 Nov 30; 6.
- Doscher C. Encouraging Colleagues and Patients to Blow the Whistle on Safety Risks. *AAPA News* 2007 Feb 28; 4.
- Kuttler H. Performance Improvement Coordinator: PA Helps Make Connecticut Hospital Safer. *AAPA News* 2007 Feb 28; 5.
- Scott D. PA Helps Develop Personal Health Records Software. *AAPA News* 2007 Apr 15; 1.
- Kuttler H. Report Highlights Link Between Safety and Patients' Health Literacy. *AAPA News* 2007 Apr 15; 5.
- Scott D. PAs Find Fully Implemented EHR System Improves Patient Service and Quality of Care. *AAPA News* 2007 Apr 30;1.

Research Abstract Presentation

Alexander LM, Delaney J, Doll M, Korber K, McNellis R, and Taft J. *Physician Assistant's Attitudes, Knowledge, and Skills about Patient Safety and Medical Errors.* [Poster] Philadelphia, PA: American Academy of Physician Assistants; 2007 May 26-30.