Patient Safety

Virginia Premier is committed to providing quality services, enhancing the safety of members, practitioners, providers and staff while preserving its financial integrity and stability to continue its mission. Virginia Premier implemented The Member Safety Program (MSP) which proactively identifies, evaluates and resolves potential safety issues. Virginia Premier is not a direct provider of care and, therefore, has a special role in improving patient safety that involves fostering a supportive environment to help practitioners and providers improve the safety of their practices and the care they deliver. Practitioners who participate on the various quality committees also play an integral role in the MSP.

According to the Agency for Healthcare Research and Quality (AHRQ), patient engagement in outpatient safety involves two related concepts: first, *educating* patients about their illnesses and medications, using methods that require patients to demonstrate understanding (such as "teach-back"); and second, *empowering* patients and caregivers to act as a safety "double-check" by providing access to advice and test results and encouraging patients to ask questions about their care. Success has been achieved in this area for patients taking high-risk medications, even in patients with low health literacy at baseline.

VPHP has ongoing initiatives to promote patient safety:

- Conducting health care assessments on each new enrollee
- Conducting surveys (i.e., CAHPS®), interviews, and focus groups
- Improving outcomes related to disease management programs or associated initiatives, i.e., prenatal and postpartum, diabetes, depression, pain management and asthma outcomes, Healthy Heartbeats, pediatric obesity, congestive heart failure, COPD, ESRD
- Investigating grievances and appeals in a timely and accurate manner
- Validating practitioner and provider credentials in a timely and accurate manner
- Enhancing prevention efforts across the continuum of care

The 2018 National Patient Safety Goals (NPSG) for Ambulatory Care promote specific improvements in patient safety. The goals highlight fundamental areas affecting member safety. VPHP educates our practitioners on the goal(s) associated with this safety initiative and a list of problematic abbreviations. The National Patient Safety Goals that are routinely provided to network practitioners and providers. The goals in their entirety can be located at:
https://www.jointcommission.org/assets/1/6/2018_AHC_NPSG_goals_final.pdf

National Patient Safety Goal on Abbreviations (6/9/2017)

In 2004, The Joint Commission created its "do not use" list of abbreviations to meet a National Patient Safety Goal. The official "do not use" list applies, at a minimum to all orders and medication-related documents that are handwritten (including free-text computer entry) as well as preprinted forms. The "Do Not Use" Abbreviation list may be found at:
https://www.jointcommission.org/facts_about_do_not_use_list/

Do Not Use	Potential Problem	Use Instead
U (unit)	Mistaken for "0" (zero), the number "4" (four) or "cc"	Write "unit"
IU (International Unit)	Mistaken for IV (intravenous) or the number 10 (ten)	Write "International Unit"
Q.D., QD, q.d., qd (daily) Q.O.D., QOD, q.o.d., qod (every other day)	Mistaken for each other Period after the Q mistaken for "I" and the "O" mistaken for "I"	Write "daily" Write "every other day"
Trailing zero (X.0 mg)[1] Lack of leading zero (.X mg)	Decimal point is missed	Write X mg Write 0.X mg
MS MSO 4 and MgSO 4	Can mean morphine sulfate or magnesium sulfate Confused for one another	Write "morphine sulfate" Write "magnesium sulfate"

1. Exception: A "trailing zero" may be used only where required to demonstrate the level of precision of the value being reported, such as for laboratory results, imaging studies that report size of lesions or catheter/tube sizes. It may not be used in medication orders or other medication-related documentation