



## PATIENT SAFETY STRATEGIES

# OUTPATIENT CARE'S SAFETY GAPS: A SYSTEM-WIDE CALL FOR CHANGE

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Approximately [25 percent](#) of adults in the U.S. receive care in an outpatient setting each month. Despite the progress made in improving inpatient safety, outpatient care remains a significant area of concern, as highlighted by a recent study, [“The Safety of Outpatient Health Care”](#) published in the *Annals of Internal Medicine*. The CRICO-funded study reveals that adverse events in outpatient settings are not only common but often preventable. With the increasing complexity of outpatient care, this gap in patient safety presents a pressing challenge for health care professionals, particularly physicians, who are at the forefront of delivering this care.

## THE PROBLEM

The study found that seven percent of patients in outpatient settings experienced at least one adverse event, with about 23 percent of these events being preventable. Older adults (65+) experienced a higher rate of events compared to other age groups, and adverse drug events accounted for almost two-thirds of all events.

While inpatient settings benefit from established safety protocols such as checklists and safety bundles, the outpatient

environment remains fragmented. Outpatient care encompasses a wide range of services, from primary care to specialty visits, diagnostics, and minor procedures, making it difficult to apply standardized safety measures across the board. This absence of cohesive safety interventions leaves patients vulnerable to preventable harm.

The study was not able to analyze diagnosis-related cases and was also largely limited to teaching hospitals in Massachusetts. Study co-author Dr. David Bates of Brigham and Women's Hospital in Boston, MA, explains in [CRICO's Safety Net podcast](#) how the findings are limited and “probably only the tip of the iceberg. There are undoubtedly things that were happening that we did not find out about.”

The study's limitations only emphasize the likely conservative estimates of the problem. Dr. David Levine of Brigham and Women's Hospital, another author of the study, states “If anything, all of those [limitations] mean that this is still a lowball estimate of harm happening in the outpatient setting, and again, just speaks to the work that we have to do.”

## A CALL TO ACTION

Dr. Levine emphasizes, “This is not an individual physician or nurse's concern. This is the system's concern, and I think together we need to work to improve.”

Despite the lack of evidence-based patient safety interventions in the outpatient setting, the authors discuss several key system-level strategies that may help improve the quality of outpatient care:

**Geriatric Specialty Care and Deprescribing:** Given that adverse events disproportionately affect older adults, the authors suggest incorporating geriatric care and deprescribing protocols, especially for managing medications in older patients. Home-based primary care may also reduce risks for this population.

**Cross-Institutional Learning:** The significant variation in adverse events across different sites indicates a need for sharing best practices between institutions to standardize and improve outpatient safety.

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**Improved Adverse Event Detection Systems:** To address the lack of evidence-based interventions, the authors recommend building robust adverse event detection systems that go beyond clinician self-reporting. This could include:

- Adopting manual and automated medical record reviews using diagnostic triggers.
- Engaging patients and caregivers as data sources to report adverse events.
- Using rapid-cycle pseudorandomized studies (A/B testing) to quickly evaluate new interventions aimed at reducing outpatient adverse events.
- Standardizing adverse event measurement and reporting, along with using implementation science for evidence-based interventions.

**Policy and Regulation:** National policy and regulatory efforts, such as expanding Medicare’s patient monitoring system to outpatient care, could lead to significant improvements in safety.

**Medication Safety Improvements:** Given that adverse drug events account for a large proportion of adverse events and based on some evidence, the authors consider improvements in electronic prescribing systems, indication-based labeling, increased contact with patients after discharge, and enhanced collaboration among clinical pharmacists and interdisciplinary teams to optimize medication management.

## ADDITIONAL RESOURCES

**CRICO Podcast:** [New Study Finds Outpatient Adverse Events Common, Often Preventable](#)

**CRICO Case Study:** [Complications from a Simple Procedure](#)

**JAMA Viewpoint Article:** [A Roadmap to Advance Patient Safety in Ambulatory Care](#)