Improving Diagnostic Safety in Medical Offices: A Resource List for Users of the AHRQ Diagnostic Safety Supplemental Items

I.   Purpose

This document includes references to websites and other publicly available resources medical offices can use to help improve the extent to which their organizational culture supports the diagnostic process, accurate diagnoses, and communication around diagnoses. While this resource list is not exhaustive, it is designed to give initial guidance to medical offices seeking information about patient safety initiatives related to diagnostic safety.

II.   How To Use This Resource List

Resources are listed in alphabetical order, organized by the Surveys on Patient Safety Culture™ (SOPS®) composite measures assessed in the Agency for Healthcare Research and Quality (AHRQ) Diagnostic Safety Supplemental Items for the SOPS Medical Office Survey, followed by general resources.

For easy access to the resources, keep the file open rather than printing it in hard copy because many of the website URLs are hyperlinked.

Feedback. To provide feedback or suggestions for resources you would like added to the list or if you have questions, email SafetyCultureSurveys@westat.com.

NOTE: The resources included in this document do not constitute an endorsement by the U.S. Department of Health and Human Services (HHS), the Agency for Healthcare Research and Quality (AHRQ), or any of their employees. HHS does not attest to the accuracy of information provided by linked sites.

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III. Contents

IV. Resources by Composite Measure

The following resources are designed to help medical offices improve areas of organizational culture assessed by the composite measures included in the AHRQ Diagnostic Safety Supplemental Items.

Composite 1. Time Availability

1. **Improving Office Practice: Working Smarter, Not Harder**

   https://www.aafp.org/fpm/2006/1100/p28.html

   The overarching goal of practice redesign is to create a well-organized office system that fosters sound medical decision making, minimizes error, and creates an atmosphere that patients, staff, and physicians can enjoy. Office organization is often accomplished through relatively simple strategies that together form a powerful force for change. This featured article from the American Academy of Family Physicians provides 12 strategies that can improve efficiency and transform practices.

2. **Innovation and Best Practices in Health Care Scheduling**

   https://nam.edu/wp-content/uploads/2015/06/SchedulingBestPractices.pdf

   In this discussion paper, the authors describe the important forces shaping wait times throughout healthcare, the evolving use of techniques and tools from other industries to improve healthcare access, and the move toward a person-centered model of care. Through their personal experiences leading their respective healthcare organizations, they have tackled these complex issues and present the lessons they have learned along the way.

3. **Reduce Scheduling Complexity**

   http://www.ihi.org/resources/Pages/Changes/ReduceSchedulingComplexity.aspx

   Complex schedules, with many appointment types, times, and restrictions, can actually increase total delay in the system because each appointment type and time creates its own differential delay and queue. Reducing the complexity ultimately decreases system delays.

   Most clinical practices use many appointment types and lengths in an effort to exert some control over the schedule. The belief is that limiting the number of a certain type of appointment scheduled on a daily basis or assigning patients to different times or types of appointments will improve access in the practice. Queuing theory, however, suggests that reducing the number of separate "lines" or "queues" for different services creates more flexibility in the system and reduces delays associated with distinct queues. Therefore, having many appointment types actually increases total delay in the system because each appointment type creates its own differential delay and queue.

4. **Strategies for Better Patient Flow and Cycle Time**
   https://www.aafp.org/fpm/2002/0600/p45.html

   This featured article from the American Academy of Family Physicians provides strategies for better patient flow and cycle time. These proven techniques can increase revenue, reduce expenses, and improve satisfaction with one's practice.

5. **Using Peer Review for Self-Audits of Medical Record Documentation**
   https://www.aafp.org/fpm/2000/0400/p28.html

   This featured article from the American Academy of Family Physicians provides information on using peer review in self-audits of medical record documentation. It describes how to get started, perform a self-audit review, and conduct postaudit followup, as well as challenges and benefits of the peer review process.

Composite 2. Testing and Referrals

1. **Closing the Loop**
   https://www.ecri.org/hit/implementation-approaches-closing-the-loop

   Working directly with healthcare organizations, the Partnership for Health IT Patient Safety recently explored how to implement tactics to close the loop on diagnostic evaluations. Clinicians were able to use their existing technology and modify their practice to better track this key information.

2. **Closing the Loop: A Guide to Safer Ambulatory Referrals in the EHR Era**
   http://www.ihi.org/resources/Pages/Publications/Closing-the-Loop-A-Guide-to-Safer-Ambulatory-Referrals.aspx

   The recommendations outlined in this publication are designed to help standardize the ways primary care practitioners activate referrals to specialists and then keep track of the information over time.

   This publication describes a nine-step, closed-loop process in which all relevant patient information is communicated to the correct person through the appropriate channels and in a timely manner. As the process involves significant collaboration among all stakeholders, the publication includes both general recommendations and recommendations specific to each step in the process and each stakeholder group.

3. **Guide to Improving Patient Safety in Primary Care Settings by Engaging Patients and Families**
    http://www.ahrq.gov/professionals/quality-patient-safety/patient-family-engagement/pfeprimarycare/index.html

    AHRQ developed this guide as a resource to help primary care practices partner with patients and their families to improve patient safety. The guide is composed of materials and resources to help primary care practices implement patient and family engagement to improve patient safety.

4. **Improving Your Laboratory Testing Process: A Step-by-Step Guide for Rapid-Cycle Patient Safety and Quality Improvement**
    https://www.ahrq.gov/hai/tools/ambulatory-care/lab-testing-toolkit.html

    The tools in this step-by-step guide can increase the reliability of the testing process in medical offices by helping providers examine how tests are managed. This guide describes how to assess an office testing process, assess patient experience and documentation, plan for improvement, implement change, and reassess to determine if the office has improved.

5. **Open Notes**
    https://www.improvediagnosis.org/practice-improvement-tools/open-notes/

    Open Notes addresses multiple aspects of diagnostic error reduction, including scheduling a referral discussed in a note. It also addresses improving communication between a patient and physician, correcting inaccurate information in the medical record, asking about concerning lab results, and communicating a diagnosis to the patient.

6. **Patient and Family Advisory Council (PFAC) Guides**
    https://www.improvediagnosis.org/pfac-guides/

    These guides are intended to serve as compendia of best and promising practices for use by PFACs and for leadership in the hospitals and health systems in which PFACs are embedded. Each guide provides foundational education about diagnostic errors and tangible ideas and suggestions for PFACs and their hospital or health system leadership to use as they address diagnostic quality and safety.

7. **SureNet**
    https://www.improvediagnosis.org/practice-improvement-tools/surenet/

    The SureNet program identifies test results or signs and symptoms that generally require followup for which the patients do not appear to have had the needed followup. It thus potentially prevents diagnostic errors by preventing patients from "falling through the cracks."

It is limited to diseases with a course of progression slow enough that one can take a few weeks to identify the cases and intervene.

Composite 3. Provider and Staff Communication Around Diagnosis

1. **Communicating Critical Test Results Toolkit**
    http://www.macoalition.org/Initiatives/CCTRToolkit.shtml

    The Massachusetts Coalition for the Prevention of Medical Errors, in cooperation with their Collaborative members, have developed sample tools such as forms, policies, and staff and patient education materials to support adoption of safety procedures.

2. **Developing a Reporting Culture: Learning From Close Calls and Hazardous Conditions**
    https://psnet.ahrq.gov/resources/resource/32494

    This new sentinel event alert from The Joint Commission explores how organizations can change their culture to promote reporting. It highlights bright spots: organizations that use a Just Culture approach to investigating errors, celebrate employees who report safety hazards, and have leaders who prioritize reporting. The Joint Commission proposes actions for all organizations, including developing incident reporting systems, promoting leadership buy-in, engaging in systemwide communication, and implementing transparent accountability structures. An Annual Perspective reviewed the context of the no-blame movement and the recent shift toward a framework of a Just Culture.

3. **Improving Diagnosis in Health Care**
    https://nap.edu/resource/21794/interactive/

    The National Academies of Sciences, Engineering, and Medicine (NAM) posted resources to facilitate communication between patients and clinicians, including videos, checklists, and additional report resources.

4. **SBAR Technique for Communication: A Situational Briefing Model**
    http://www.ihi.org/resources/Pages/Tools/SBARTechniqueforCommunicationASituationalBriefingModel.aspx
    http://www.ihi.org/resources/Pages/Tools/SBARTrainingScenariosandCompetencyAssessment.aspx (both pages require free account setup and login)

    The SBAR (Situation-Background-Assessment-Recommendation) technique provides a framework for communication between members of the healthcare team about a patient's condition. This downloadable tool from IHI contains two documents:

    - "Guidelines for Communicating With Physicians Using the SBAR Process" explains how to carry out the SBAR technique.

- "SBAR Report to Physician About a Critical Situation" is a worksheet/script a provider can use to organize information when preparing to communicate with a physician about a critically ill patient.

The SBAR training scenarios reflect a range of clinical conditions and patient circumstances and are used in conjunction with other SBAR training materials to assess frontline staff competency in using the SBAR technique for communication.

5. **TeamSTEPPS® — Team Strategies and Tools to Enhance Performance and Patient Safety**
   https://www.ahrq.gov/teamstepps
   https://www.ahrq.gov/teamstepps/officebasedcare/index.html (Office-Based Care version)

   TeamSTEPPS is a teamwork system designed for healthcare professionals that is:

   - A powerful solution to improving patient safety within an organization.
   - An evidence-based teamwork system to improve communication and teamwork skills among healthcare professionals.
   - A source for ready-to-use materials and a training curriculum to successfully integrate teamwork principles into all areas of a healthcare system.
   - Scientifically rooted in more than 20 years of research and lessons from the application of teamwork principles.
   - Developed by the Department of Defense's Patient Safety Program in collaboration with AHRQ.

   The TeamSTEPPS curriculum is an easy-to-use comprehensive multimedia kit that contains:

   - Fundamentals modules in text and presentation format.
   - A pocket guide that corresponds with the essentials version of the course.
   - Video vignettes to illustrate key concepts.
   - Workshop materials on change management, coaching, and implementation.

V. General Resources

1. **Diagnostic Error Educational Tools**
   http://patientsafety.pa.gov/pst/Pages/Diagnostic%20Error/hm.aspx#

   Diagnosis involves a complex system with many team members and numerous interdependent steps, all of which can make it challenging to identify and learn from failures in the process. The Pennsylvania Patient Safety Authority developed these tools, which include sample handouts, worksheets, and checklists.

2. **Diagnostic Safety Toolkit**
   https://www.childrenshospitals.org/Quality-and-Performance/Patient-Safety/Resources/Diagnostic-Safety-Toolkit

   The diagnostic safety toolkit is designed to use anywhere in an organization and with any diagnosis. The toolkit includes a patient safety alert, case studies, a template for assessing internal communication gaps, a template for conducting diagnostic timeouts, and an additional resource list.

3. **Harnessing Improvement to Reduce Diagnostic Errors and Delays (Podcast)**
   http://www.ihi.org/resources/Pages/AudioandVideo/WIHIImprovingDiagnosisErrors.aspx

   In this podcast from IHI, four speakers discussed diagnostic error, including how to determine the extent of these errors in an organization and the best improvement approaches to bring about solutions.

4. *Improving Diagnosis in Medicine* **Change Package**
   https://www.improvediagnosis.org/improving-diagnosis-in-medicine-change-package/

   The *Improving Diagnosis in Medicine* change package is the result of a collaboration between the Health Research & Educational Trust (HRET) Hospital Improvement Innovation Network (HIIN) team and the Society to Improve Diagnosis in Medicine (SIDM), with contributions of patients and their families. This resource is a tool to help reduce patient safety incidents caused by actions during the diagnostic process.

5. **Kaiser Permanente Diagnostic Excellence Video Series**
   https://kpactionplans.org/dex/?kp_shortcut_referrer=kp.org/scal/dex

   The videos in this series are short and cover a wide range of diagnostic error topics, including promoting teamwork throughout the diagnostic process, documenting differential diagnoses, and understanding bias.

6. **Reducing Diagnostic Errors in Primary Care Pediatrics Toolkit – Project RedDE!**
    https://www.aap.org/en-us/professional-resources/quality-improvement/Project-RedDE/Pages/Project-RedDE.aspx

    The *Reducing Diagnostic Errors in Primary Care Pediatrics* (Project RedDE!) Toolkit aims to assist primary care practice teams with a systematic approach to reduce diagnostic errors and improve care for children. This toolkit will walk teams through the measurement, screening, recognition, diagnosis, followup, and reduction of diagnostic errors associated with pediatric elevated blood pressure, adolescent depression, and laboratory testing through improvement science methods. By using this toolkit, primary care providers will be able to:

    - Learn how to implement a systematic approach to providing safe and quality care to patients.
    - Test strategies for improving care.
    - Access tools and best practice from national experts.
    - Reduce the likelihood of patient harm by identifying and decreasing diagnostic errors.

7. **Safety Assurance Factors for EHR Resilience (SAFER) Guides**
    https://www.healthit.gov/safer/

    The SAFER Guides are designed to help healthcare organizations conduct self-assessments to optimize the safety and safe use of EHRs in the following areas: High Priority Practices, Organizational Responsibilities, Contingency Planning, System Configuration, System Interfaces, Patient Identification, Computerized Provider Order Entry With Decision Support, Test Results Reporting and Follow-Up, and Clinician Communication.

8. **Society to Improve Diagnosis in Medicine Resources**
    https://www.improvediagnosis.org/resources-for/

    The Society to Improve Diagnosis in Medicine features educational resources for trainees, practitioners, and educators on clinical reasoning, critical thinking, and system factors that underlie diagnostic error, as well as strategies to improve diagnostic performance.

VI. Alphabetical Index of Resources