Improving Patient Safety in Medical Offices: A Resource List for Users of the AHRQ Medical Office Survey on Patient Safety Culture

I. Purpose

This document provides a list of references to websites and other publicly available, practical resources medical offices can use to improve patient safety culture and patient safety. While this resource list is not exhaustive, it is designed to give initial guidance to medical offices seeking information about patient safety initiatives.

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) Medical Office Survey on Patient Safety Culture, 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 and cross-referenced to other resources within the document.

Feedback. Suggestions for resources you would like added to the list, questions about the survey, or requests for assistance can be addressed to: 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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SOPS™

III. Contents

IV. Resources by Composite

The following resources are organized according to the relevant Medical Office Survey on Patient Safety Culture composite measures they are designed to help improve. Some resources are duplicated and cross-referenced because they may apply to more than one composite.

Composite 1. Communication About Error

1. **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.

2. **Incident Decision Tree**
   https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/patient-safety-resources/resources/advances-in-patient-safety/vol4/Meadows.pdf

   The National Patient Safety Agency has developed the Incident Decision Tree to help National Health Service managers in the United Kingdom determine a fair and consistent course of action toward staff involved in patient safety incidents. Staff can use this decision tree when analyzing an error or adverse event in an organization to help identify how human factors and systemic issues contributed to the event. The Incident Decision Tree supports the aim of creating an open culture, where employees feel able to report patient safety incidents without undue fear of the consequences.

3. **Just Culture**
   a. **Nursing 2015 Just Culture Toolkit**
      https://nursing2015.wordpress.com/blue-team/blue-team-documents/just-culture-tool-kit-building/

      This website provides a definition of Just Culture, presentations on Just Culture, a case study, and videos.

   b. **Just Culture**
      https://www.unmc.edu/patient-safety/patientsafetyculture/just-culture.html

      This website provides links to ways to engage and teach a Just Culture, execute a Just Culture, and evaluate a Just Culture.

c. **Outcome Engenuity**
https://www.outcome-eng.com/david-marx-introduces-just-culture/

This website provides resources and videos on Just Culture.

4. **Living a Culture of Patient Safety Policy and Brochure**
http://www.ihi.org/resources/Pages/Tools/LivingaCultureofPatientSafety.aspx (requires free account setup and login)

St. John's Mercy Medical Center created an institutionwide policy regarding nonpunitive reporting, as well as a brochure, Living a Culture of Patient Safety, that was developed by its Culture of Safety Subcommittee, signed by the president, and mailed to all coworker homes. The brochure reinforces the nonpunitive reporting policy and encourages all coworkers to report errors.

5. **Provide Feedback to Frontline Staff**
http://www.ihi.org/resources/Pages/Changes/ProvideFeedbacktoFrontLineStaff.aspx (requires free account setup and login)

Feedback to frontline staff is a critical component of demonstrating a commitment to safety and ensuring that staff members continue to report safety issues. This Institute for Healthcare Improvement web page identifies tips and tools for providing feedback.

6. **Shining a Light: Safer Health Care Through Transparency**
http://www.ihi.org/resources/Pages/Publications/Shining-a-Light-Safer-Health-Care-Through-Transparency.aspx (requires free account setup and login)

Defining transparency as "the free flow of information that is open to the scrutiny of others," this report recommends ways to bring greater transparency in four domains: between clinicians and patients; among clinicians within an organization; between organizations; and between organizations and the public. It makes the case that true transparency will result in improved outcomes, fewer medical errors, more satisfied patients, and lower costs of care. Case studies are included to document how transparency is practiced in each of the domains.

Composite 2. Communication Openness

1. **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.

Composite 3. Office Processes and Standardization

1. **Create Contingency Plans**
   http://www.ihi.org/resources/Pages/Changes/CreateContingencyPlans.aspx (requires free account setup and login)

   The natural variation in supply and demand that occurs as part of the everyday functioning of a practice often creates problems that contingency plans can address. To avoid disrupting the normal flow of clinic practice, clinics agree on a standard protocol to follow for each event, including clear responsibilities for each staff member. This Institute for Healthcare Improvement web page provides information about how to create contingency plans.

2. **Mapping and Redesigning Workflow**
   https://www.ahrq.gov/professionals/prevention-chronic-care/improve/system/pfhandbook/mod5.html

   This module from AHRQ defines workflow and provides information on how to map and redesign key workflows.

3. **Workflow Assessment for Health IT Toolkit**
   http://healthit.ahrq.gov/health-it-tools-and-resources/workflow-assessment-health-it-toolkit

   A key to successful implementation of health information technology (health IT) is to recognize its impact on both clinical and administrative workflow. Once implemented, health IT can provide information to help you reorganize and improve your workflow. This toolkit is designed for people and organizations interested or involved in the planning, design, implementation, and use of health IT in ambulatory care.

Composite 4. Organizational Learning

1. **Root Cause Analysis**
   a. **Department of Veterans Affairs National Center for Patient Safety –Root Cause Analysis**
      http://www.patientsafety.va.gov/professionals/onthejob/rca.asp

      The National Center for Patient Safety uses a multidisciplinary team approach, known as root cause analysis (RCA), to study healthcare-related adverse events and close calls. The goal of the RCA process is to find out what happened, why it happened, and how to prevent it from happening again. Because the Center's Culture of Safety is based on prevention, not punishment, RCA teams investigate how well patient care systems function. The focus is on the "how" and the "why," not on the "who."

   b. **Root Cause Analysis in Health Care: Tools and Techniques**
      https://www.jcrinc.com/assets/1/14/EBRCA15Sample.pdf

      This document is intended to help healthcare organizations prevent system failures by using root cause analysis to:

      - Identify causes and contributing factors of a sentinel event or cluster of incidents.
      - Identify system vulnerabilities that could lead to patient harm.
      - Implement risk reduction strategies that decrease the likelihood of a recurrence of the event or incidents.
      - Determine effective and efficient ways of measuring and improving performance.

   c. **RCA2: Improving Root Cause Analyses and Actions To Prevent Harm**
      http://www.ihi.org/resources/Pages/Tools/RCA2-Improving-Root-Cause-Analyses-and-Actions-to-Prevent-Harm.aspx (requires free account setup and login)

      With a grant from The Doctors Company Foundation, the National Patient Safety Foundation convened a panel of subject matter experts and stakeholders to examine best practices around RCAs. The panel developed guidelines to help health professionals standardize the process and improve the way they investigate medical errors, adverse events, and near-misses. To focus on the objective of preventing future harm, this updated process focuses on actions to take: Root Cause Analyses and Actions, or RCA2 (RCA "squared").

2. **Patient Safety Tools for Physician Practices**
   http://www.hret.org/quality/projects/pppsa.shtml

   Supported by the Commonwealth Fund, the Health Research & Educational Trust and its partners at the Institute for Safe Medication Practices and the Medical Group Management Association Center for Research developed patient safety tools for physician practices. Pathways for Patient Safety™ is a three-part toolkit to help outpatient care settings improve safety in three areas: working as a team, assessing where you stand, and creating medication safety.

3. **Plan-Do-Study-Act (PDSA) Steps and Worksheet**
   http://www.ihi.org/resources/Pages/HowtoImprove/ScienceofImprovementTestingChanges.aspx
   http://www.ihi.org/resources/Pages/Tools/PlanDoStudyActWorksheet.aspx (both pages require free account setup and login)

   The Plan-Do-Study-Act (PDSA) cycle is shorthand for testing a change by developing a plan to test the change (Plan), carrying out the test (Do), observing and learning from the results (Study), and determining needed modifications (Act). The first website listed provides the steps in the PDSA cycle and the second website listed provides a PDSA Worksheet, a useful tool for documenting a test of change.

4. **The Practice Facilitation Handbook: Training Modules for New Facilitators and Their Trainers**
   http://www.ahrq.gov/professionals/prevention-chronic-care/improve/system/pfhandbook/index.html

   This AHRQ handbook is designed to assist in the training of new practice facilitators as they begin to develop the knowledge and skills to support meaningful improvement in primary care practices. Practice facilitators are specially trained to work with primary care practices to improve the quality of care, patient experiences with care, and patient outcomes. This handbook is based on a demonstration program that used facilitators in safety-net practices to assist in training new practice facilitators. It consists of 21 training modules, each 30 to 90 minutes long, with varying requirements for presession preparation for learners.

5. **Quality Improvement Fundamentals Toolkit**
   http://www.leadingageny.org/home/assets/File/QI_Fundamentals_toolkit.pdf

   This toolkit was developed by the Centers for Medicare & Medicaid Services and can be used to help identify opportunities for improvement and develop improvement processes.

6. **Will It Work Here?: A Decisionmaker's Guide to Adopting Innovations**
   http://www.innovations.ahrq.gov/guide/guideTOC.aspx

   The goal of this guide is to promote evidence-based decision making and help decision makers determine whether an innovation would be a good fit or an appropriate stretch for their healthcare organization

Composite 5. Owner/Managing Partner/Leadership Support for Patient Safety

1. **A Framework for Safe, Reliable, and Effective Care**
   http://www.ihi.org/resources/Pages/IHIWhitePapers/Framework-Safe-Reliable-Effective-Care.aspx (requires free account setup and login)

   The Framework for Safe, Reliable, and Effective Care describes the key strategic, clinical, and operational components involved in achieving safe and reliable operational excellence—a "system of safety," not just a collection of standalone safety improvement projects.

2. **Conduct Patient Safety Leadership WalkRounds™**
   http://www.ihi.org/resources/Pages/Changes/ConductPatientSafetyLeadershipWalkRounds.aspx
   http://www.ihi.org/resources/Pages/Tools/PatientSafetyLeadershipWalkRounds.aspx (both pages require free account setup and login)

   Senior leaders can demonstrate their commitment to safety and learn about the safety issues in their organization by making regular rounds for the sole purpose of discussing safety with the staff. These Institute for Healthcare Improvement (IHI) website links discuss the benefits of management making regular rounds, gives tips for doing the rounds, and links to resources. These rounds are especially effective in conjunction with safety briefings.

3. **Leading a Culture of Safety: A Blueprint for Success**
   http://www.ihi.org/resources/Pages/Publications/Leading-a-Culture-of-Safety-A-Blueprint-for-Success.aspx (requires free account setup and login)

   Leading a Culture of Safety: A Blueprint for Success was developed to bridge a gap in knowledge and resources by providing chief executive officers and other healthcare leaders with a useful tool for assessing and advancing their organization's culture of safety. This guide can be used to help determine the current state of an organization's journey, inform dialogue with the board and leadership team, and help leaders set priorities.

4. **Safety Briefings and Safety Huddles**
   Two resources are available for conducting safety briefings and safety huddles with the goal of increasing safety awareness among frontline staff and helping develop a culture of safety.

   a. **Safety Huddle Results Collection Tool**
      http://www.ihi.org/resources/Pages/Tools/SafetyHuddleResultsCollectionTool.aspx
      (requires free account setup and login)

      This tool can be used to aggregate data collected during tests of safety briefings (also called "safety huddles"). When organizations first test safety briefings, it is important to gather information about staff perceptions of value. However, this information need not be collected at every briefing, but only at the beginning and end of the test. If an organization then decides to permanently implement safety briefings, other data collection tools may be

used to track important information, such as issues raised by staff and opportunities to improve safety.

b. **Guide to Safety Huddles**
http://www.wsha.org/wp-content/uploads/Worker-Safety_SafetyHuddleToolkit_3_27_15.pdf

This guide to conducting safety huddles defines a safety huddle and suggests who should attend, when they should occur, and how to get a huddle program started. Appendixes include safety huddle process maps, templates, and tools.

Composite 6. Patient Care Tracking/Followup

1. **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.

2. **Improving Your Laboratory Testing Process: A Step-by-Step Guide for Rapid-Cycle Patient Safety and Quality Improvement**
https://www.ahrq.gov/professionals/quality-patient-safety/hais/tools/ambulatory-care/labtesting-toolkit.html

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

3. **Patient Notification Toolkit**
http://www.cdc.gov/injectionsafety/pntoolkit/index.html

This toolkit provides guidance and resources to help organizations with a patient notification following identification of an infection control lapse or disease transmission.

Composite 7. Staff Training

1. **AHRQ Patient Safety Education and Training Catalog**
http://psnet.ahrq.gov/pset/index.aspx

AHRQ's Patient Safety Education and Training Catalog consists of patient safety programs currently available in the United States. The catalog, featured on AHRQ's Patient Safety Network site, offers a database of patient safety education and training programs, each tagged for easy

searching and browsing. The database identifies a number of characteristics of the programs, including clinical area, program and learning objectives, evaluation measures, and cost.

Composite 8. Teamwork

1. **Patient Safety Primer: Teamwork Training**
   https://psnet.ahrq.gov/primers/primer/8

   Providing safe healthcare depends on highly trained individuals with disparate roles and responsibilities acting together in the best interests of the patient. AHRQ's Patient Safety Primer explains this topic further and provides links to more information on teamwork training.

2. **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 your 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 your 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.

Composite 9. Work Pressure and Pace

1. **Manage Panel Size and Scope of the Practice**
   http://www.ihi.org/resources/Pages/Changes/ManagePanelSizeandScopeofthePractice.aspx
   (requires free account setup and login)

   Managing panel size and the scope of the practice allows a team to balance supply and demand and ensures that they can complete tasks on time. This Institute for Healthcare Improvement (IHI) web page also includes links that contain more specific information and strategies for managing panel size and the scope of the practice.

2. **Predict and Anticipate Patient Needs**
   http://www.ihi.org/resources/Pages/Changes/PredictandAnticipatePatientNeeds.aspx (requires free account setup and login)

   This IHI website includes links to specific information and strategies on advance planning, including predicting and anticipating patient needs in the context of clinic workflow (e.g., to arrange for equipment or tests for their visit).

3. **Recalibrate the System by Working Down the Backlog**
   http://www.ihi.org/resources/Pages/Changes/RecalibratetheSystembyWorkingDowntheBacklog.aspx (requires free account setup and login)

   This IHI resource provides information for medical offices on how to reduce and eliminate backlog appointments. Included is a link to a Backlog Reduction Worksheet that helps users understand the extent of their backlog.

V. Patient Safety and Quality Issues

Access to Care

1. **Balance Supply and Demand on a Daily, Weekly, and Long-Term Basis**
   http://www.ihi.org/resources/Pages/Changes/BalanceSupplyandDemandonaDailyWeeklyandLongTermBasis.aspx (requires free account setup and login)

   The foundation of improved access scheduling is matching supply and demand on a daily, weekly, and monthly basis. This Institute for Healthcare Improvement (IHI) web page contains information on communication methods to manage the daily and weekly supply and demand variation and to anticipate and plan for recurring seasonal events.

2. **Decrease Demand for Appointments**
   http://www.ihi.org/resources/Pages/Changes/DecreaseDemandforAppointments.aspx
   (requires free account setup and login)

   One key way for a healthcare system to improve access is to reduce unnecessary demand for various services so that patients needing a particular service can receive it in a timely way. This IHI web page contains information on decreasing demand for appointments, such as using alternatives to in-person visits (e.g., telephone, e-mail).

3. **Measure and Understand Supply and Demand**
   http://www.ihi.org/resources/Pages/Changes/MeasureandUnderstandSupplyandDemand.aspx
   (requires free account setup and login)

   Improving access is all about getting supply and demand in equilibrium, meaning there is no backlog of appointments and no delay between when the demand is initiated and when the service is delivered. This IHI web page contains information on how to measure and understand supply and demand.

4. **Optimize the Care Team**
   http://www.ihi.org/resources/Pages/Changes/OptimizetheCareTeam.aspx (requires free account setup and login)

   Optimizing the care team is critical to maximizing the supply of the clinic and improving the daily workflow. This IHI web page contains information on decreasing demand for appointments.

5. **Reduce Scheduling Complexity**
   http://www.ihi.org/resources/Pages/Changes/ReduceSchedulingComplexity.aspx (requires free account setup and login)

   Complex schedules, with many appointment types, times, and restrictions, can increase total delay in the system because each appointment type and time creates its own differential delay and queue. This IHI web page contains information on how to reduce scheduling complexity.

Patient Identification

1. **2019 National Patient Safety Goals: Ambulatory Health Care**
   https://www.jointcommission.org/assets/1/6/2019_AHC_NPSGs_final.pdf

   The purpose of the Joint Commission Ambulatory Care National Safety Goals is to improve patient safety in an ambulatory setting. The goals focus on problems in healthcare safety and how to solve them.

Charts and Medical Records

1. **Health Information Technology Toolkit for Physician Offices**
   http://www.stratishealth.org/expertise/healthit/clinics/clinictoolkit.html

   The Health Information Technology Toolkit for Physician Offices helps these healthcare organizations assess their readiness, plan, select, implement, make effective use of, and exchange important information about their clients. The toolkit contains numerous resources, including tools for telehealth, health information exchange, and personal health records.

Medical Equipment

1. **Medical Device Evaluation Forms**
   http://www.tdict.org/evaluation2.html

   The Training for Development of Innovative Control Technologies (TDICT) Project is a collaborative effort of frontline healthcare workers, product designers, and industrial hygienists. The project is dedicated to preventing exposure to blood through better design and evaluation of medical devices and equipment. In conjunction with frontline healthcare workers, TDICT has developed criteria for evaluation of several medical devices.

Medication

1. **ISMP List of High-Alert Medications in Community/Ambulatory Healthcare**
   http://forms.ismp.org/communityRx/tools/ambulatoryhighalert.asp

   This fact sheet provides a list of high-alert medications commonly used in ambulatory care and recommends strategies to reduce risk of errors.

2. **Patient Safety Primer: Medication Reconciliation**
   https://psnet.ahrq.gov/primers/primer/1/medication-reconciliation

   Medication reconciliation refers to the process of avoiding inadvertent inconsistencies across transitions in care. It involves reviewing the patient's complete medication regimen at the time of admission, transfer, and discharge and comparing it with the regimen being considered for the new setting of care. AHRQ's Patient Safety Network explains this topic further and provides links for more information on what is new in medication reconciliation.

3. **A Toolset for E-Prescribing Implementation in Physician Offices**
   http://healthit.ahrq.gov/health-it-tools-and-resources/implementation-toolsets-e-prescribing/toolset-e-prescribing

   The purpose of this toolset is to provide practices with the knowledge and resources to implement e-prescribing successfully. The toolset is designed for use by a diverse range of provider organizations, from small, independent offices to large medical groups. The toolset also includes specific tools to support planning and decision making, such as surveys to determine whether an organization is ready for e-prescribing, worksheets for planning the implementation and monitoring progress, and templates for communicating the launch to patients.

Diagnostics and Tests

1. **Society to Improve Diagnosis in Medicine: Educational Resources**
   http://www.improvediagnosis.org/?page=Resources

   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, and strategies to improve diagnostic performance.

Cross-references to resources already described:

- Composite 2. Patient Care Tracking/Followup, #2, Improving Your Office Testing Process: A Toolkit for Rapid-Cycle Patient Safety and Quality Improvement
- Composite 2. Patient Care Tracking/Followup, #7, Primary Care Practices Improve Patient Satisfaction With Communication of Outpatient Laboratory Test Results

VI. Information Exchange With Other Settings

1. **Official "Do Not Use" List Fact Sheet**
   https://www.jointcommission.org/assets/1/18/Do_Not_Use_List_9_14_18.pdf

   The Joint Commission issued a Sentinel Event Alert on medical abbreviations. Its Board of Commissioners approved a National Patient Safety Goal requiring accredited organizations to develop and implement a list of abbreviations, acronyms, and symbols not to use.

2. **Health Information Exchange Projects**
   http://healthit.ahrq.gov/health-it-tools-and-resources/health-information-exchange-hie-evaluation-toolkit

   The AHRQ National Resource Center for Health IT has a toolkit for health information exchange projects. The toolkit offers suggestions and examples for evaluating the exchange of health information between various community stakeholders (e.g., providers, health departments, pharmacies, laboratories). Evaluation of data exchange is crucial to determining the impact of this new type of health IT project on healthcare quality and safety.

3. **Health Information Security and Privacy Collaboration Toolkit**
   http://healthit.ahrq.gov/health-it-tools-and-resources/health-information-security-and-privacy-collaboration-toolkit

   This toolkit provides guidance for conducting organization-level assessments of business practices, policies, and State laws that govern the privacy and security of health information exchange. It was developed as part of the Health Information Security and Privacy Collaboration project jointly funded by AHRQ and the Office of the National Coordinator for Health Information Technology.

4. **Regional Health eDecisions: A Guide to Connecting Health Information Exchange in Primary Care**
   http://healthit.ahrq.gov/sites/default/files/docs/citation/eDecisionsReport.pdf

   This AHRQ guide outlines a framework for primary care practices to connect to regional health information exchanges. It establishes a blueprint for assessing organizational readiness for connecting an electronic health record to a Regional Health Information Organization (RHIO), creating leadership and clinician buy-in for information exchange, addressing technical issues, and ensuring that data acquired from information exchange are accessible within clinician workflows.

   Using practical insights from Oklahoma Physicians Resource/Research Network, the guide provides a framework for using information obtained from RHIOs for clinical decision making and delivery of preventive services. With special sections for practice leaders, IT staff, and practice personnel, the guide outlines practical approaches to achieve optimal connectedness with RHIOs to support patient-centered care.

5. **Transitions of Care Checklist**
   http://www.ntocc.org/Portals/0/PDF/Resources/TOC_Checklist.pdf

   The National Transitions of Care Coalition Advisory Task Force has released a transitions of care list that provides a detailed description of effective patient transfer between practice settings. This process can help to ensure that patients and their critical medical information are transferred safely, quickly, and efficiently.

VII. Overall Ratings on Quality and Patient Safety

Patient Centered

1. **AHRQ Patient Centered Medical Home (PCMH) Resource Center**
   https://pcmh.ahrq.gov/

   AHRQ recognizes that revitalizing the Nation's primary care system is foundational to achieving high-quality, accessible, efficient healthcare for all Americans. The primary care medical home, also referred to as the patient-centered medical home (PCMH), advanced primary care, and the healthcare home, is a promising model for transforming the organization and delivery of primary care. The Resource Center web page provides links to tools and resources on the five domains of PCMH, three foundational supports, and implementation of PCMH.

2. **CAHPS® Surveys**
   https://www.cahps.ahrq.gov/surveys-guidance/index.html

   The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) program is a multiyear AHRQ initiative to support the assessment of consumers' experiences with healthcare. This website provides information on the CAHPS® surveys, including the questionnaire and administration guidelines, as well as reporting and benchmarking data.

   - CAHPS® Clinician & Group (CG-CAHPS®) Survey with Patient-Centered Medical Home (PCMH) Items
   - CAHPS® Health Information Technology Item Set
   - CAHPS® Health Literacy Item Set

3. **Institute for Patient- and Family-Centered Care**
   http://www.ipfcc.org/resources/downloads-tools.html

   The Institute for Patient- and Family-Centered Care offers a wide variety of free downloadable PDFs to use in your organization. This website features many free resources, including a toolkit to enhance safety and quality and a work plan for starting a patient and family advisory council.

4. **Patient Care Experience Observation Exercise**
   http://www.ihi.org/resources/Pages/Tools/PatientCareExperienceObservationExercise.aspx
   (requires free account setup and login)

   This tool was developed by the Institute for Healthcare Improvement to allow care team members to learn about and understand the experience of care in their organization from the patient and family perspective, and not from assumptions that may be made by those who are providing care. Care team members select a patient care process to observe and then document their observations about the care experience from the patient and family perspective in a non-judgmental way, using the observations to inform improvements to the care experience.

5. **Patient-Centered Primary Care Collaborative**
   https://www.pcpcc.org/webinars

   The Patient-Centered Primary Care Collaborative is a coalition of major employers, consumer groups, patient quality organizations, health plans, labor unions, hospitals, physicians, and many others who have joined together to develop and advance the patient centered medical home. The collaborative has more than 200 members. The PCPCC website offers a variety of Webinars related to Accountable Care Organizations (ACOs), care coordination, education and training, eHealth, employers, and transformation.

6. **The Patient Education Materials Assessment Tool (PEMAT) and User's Guide**
   http://www.ahrq.gov/professionals/prevention-chronic-care/improve/self-mgmt/pemat/index.html

   The Patient Education Materials Assessment Tool (PEMAT) is a systematic method to evaluate and compare the *understandability* and *actionability* of patient education materials. It is designed as a guide to help determine whether patients will be able to understand and act on information. Separate tools are available for use with print and audiovisual materials.

Effective

No resources identified at this time.

Timely

Cross-reference to resource already described:

- Composite 9. Patient Safety and Quality Issues, Access to Care.

Efficient

1. **Choosing Wisely**
   http://www.choosingwisely.org/resources/

   Choosing Wisely is an initiative of the American Board of Internal Medicine Foundation in partnership with Consumer Reports that seeks to advance a national dialogue on avoiding wasteful or unnecessary medical tests, treatments, and procedures.

2. **Going Lean in Healthcare**
   https://www.entnet.org/sites/default/files/GoingLeaninHealthCareWhitePaper-3.pdf

   Examples in this Institute for Healthcare Improvement (IHI) paper of Lean thinking in healthcare show that, when applied rigorously and throughout an entire organization, Lean principles can have a positive impact on productivity, cost, quality, and timely delivery of services.

3. **Improve Workflow and Remove Waste**
   http://www.ihi.org/resources/Pages/Changes/ImproveWorkFlowandRemoveWaste.aspx
   (requires free account setup and login)

   Improving the flow of work and eliminating waste ensures that the clinical office runs as efficiently and effectively as possible. This IHI web page provides information about how to improve workflow.

Equitable

1. **Health Research & Educational Trust (HRET) Disparities Toolkit**
   http://www.hretdisparities.org/

   The Health Research & Educational Trust (HRET) Disparities Toolkit provides resources and information to help medical offices collect demographic information from patients, such as race, ethnicity, and primary language data. This toolkit helps offices plan to improve quality of care for all populations.

VIII. Overall Perceptions of Patient Safety and General Resources

1. **AAAHC Institute Research and Toolkits**
   http://www.aaahc.org/en/institute/Patient-Safety-Toolkits1/

   Each patient safety toolkit from the Accreditation Association for Ambulatory Health Care, Inc., includes a concise overview of evidence-based information on a specific topic, references, and one or more patient assessment tools to aid in clinical decision-making and patient management.

2. **AHRQ Impact Case Studies**
   http://www.ahrq.gov/policymakers/case-studies/index.html?search_api_views_fulltext=patient+safety

   AHRQ's evidence-based tools and resources are used by organizations nationwide to improve the quality, safety, effectiveness, and efficiency of healthcare. This subset of the Agency's Impact Case Studies specific to patient safety highlights these successes, describing the use and impact of AHRQ-funded tools by State and Federal policy makers, health systems, clinicians, academicians, and other professionals.

3. **Appoint a Safety Champion for Every Unit**
   http://www.ihi.org/resources/Pages/Changes/AppointaSafetyChampionforEveryUnit.aspx
   (requires free account setup and login)

   Having a designated safety champion in every department and patient care unit demonstrates the organization's commitment to safety and may make other staff members feel more comfortable about sharing information and asking questions. This IHI web page identifies tips for appointing a safety champion.

4. **Atlas of Integrated Behavioral Health Care Quality Measures**
   https://integrationacademy.ahrq.gov/resources/ibhc-measures-atlas

   This guide, for primary healthcare practitioners, researchers, and measurement experts, provides measures and practices for integrating behavioral healthcare into primary care, or preparing for integration. The atlas focuses on the components of quality that support and guide integration of services by:

   - Presenting a framework for understanding measurement of integrated care.
   - Providing a list of existing measures relevant to integrated behavioral healthcare.
   - Organizing the measures by the framework and by user goals to facilitate selection of measures.

5. **CAHPS® Improvement Guide**
   https://cahps.ahrq.gov/quality-improvement/improvement-guide/improvement-guide.html

   The extensive and growing use of Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys to assess the quality of health plans, medical groups, and other organizations has created a demand for practical strategies that organizations can use to improve patients' experiences with care. This guide is designed to help meet this need. It is aimed at executives, managers, physicians, and other staff responsible for measuring performance and improving the quality of services provided by health plans, medical groups, and individual physicians. This guide includes new improvement interventions and offers additional resources.

6. **Department of Defense Patient Safety Program Toolkits**
   http://www.health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Quality-And-Safety-of-Healthcare/Patient-Safety/Patient-Safety-Products-And-Services/Toolkits

   The Department of Defense Patient Safety Program is a comprehensive program with the goal of establishing a culture of patient safety and quality within the Military Health System. Patient Safety Program Toolkits are available and intended to be small, self-contained resource modules for training and application. Available toolkits and guides include:

   - Briefs and Huddles.
   - Debriefs.
   - Eliminating Wrong Site Surgery and Procedure Events.
   - MHS Leadership Engagement.
   - Patient Falls Reduction.
   - RCA Resource Guide.
   - SBAR.

7. **Engaging Patients in Improving Ambulatory Care**
   http://www.rwjf.org/content/dam/farm/toolkits/toolkits/2013/rwjf404402

   This compendium includes strategies and tools to engage patients in healthcare improvement that have been implemented in Maine, Oregon, and Humboldt County, California.

8. **Framework for Improving Joy in Work**
   http://www.ihi.org/resources/Pages/IHIWhitePapers/Framework-Improving-Joy-in-Work.aspx
   (requires free account setup and login)

   This IHI white paper serves as a guide for healthcare organizations to engage in a participative process where leaders ask colleagues at all levels of the organization, "What matters to you?" This approach enables them to better understand the barriers to joy in work and to create meaningful, high-leverage strategies to address these issues.

9. **Hand Hygiene in Healthcare Settings**
   http://www.cdc.gov/handhygiene/training.html

   The Centers for Disease Control and Prevention's Hand Hygiene in Healthcare Settings provides healthcare workers and patients with a variety of resources, including guidelines for providers and patient empowerment materials. Other resources include the latest technological advances in measuring hand hygiene adherence, frequently asked questions, and links to promotional and educational tools published by the World Health Organization, universities, and health departments.

10. **HealthPartners Ambulatory Safety Toolkit**
    https://www.healthpartners.com/ucm/groups/public/@hp/@public/documents/documents/vgn_pdf_56420.pdf

    This HealthPartners toolkit provides practical tools and suggestions that can be incorporated into clinical operations to eliminate harm due to error in the delivery of care.

11. **National Committee for Quality Assurance Patient-Centered Medical Home Recognition**
    http://www.ncqa.org/Programs/Recognition/Practices/PatientCenteredMedicalHomePCMH.aspx

    NCQA Patient-Centered Medical Home (PCMH) Recognition is the most widely used way to transform primary care practices into medical homes. The patient-centered medical home is a way of organizing primary care that emphasizes care coordination and communication to transform primary care into "what patients want it to be." Medical homes can lead to higher quality and lower costs, and can improve patients' and providers' experience of care.

12. **Patient Safety Primer: Medication Errors**
    https://psnet.ahrq.gov/primers/primer/23

    A growing evidence base supports specific strategies to prevent adverse drug events (ADEs). AHRQ's Patient Safety Network outlines strategies providers can use at each stage of the medication use pathway – prescribing, transcribing, dispensing, and administration – to prevent ADEs. These strategies range from computerized provider order entry and clinical decision support to minimizing nurse disruption and providing better patient education and medication labeling. The primer also identifies known risk factors for ADEs, including health literacy, patient characteristics, high-alert medications and transitions in care.

13. **Patient Safety Primer: Patient Safety in Ambulatory Care**
    https://psnet.ahrq.gov/primers/primer/16

    Although the vast majority of healthcare takes place in the outpatient, or ambulatory care, setting, efforts to improve safety have mostly focused on the inpatient setting. However, a body of research dedicated to patient safety in ambulatory care has emerged over the past few years. These efforts have identified and characterized factors that influence safety in office practice, the types of errors commonly encountered in ambulatory care, and potential strategies for improving ambulatory safety.

14. **Patient Safety Primer: Culture of Safety**
    https://psnet.ahrq.gov/primers/primer/5

    The concept of safety culture originated outside healthcare in studies of high-reliability organizations. These organizations consistently minimize adverse events despite carrying out intrinsically complex and hazardous work. High-reliability organizations maintain a commitment to safety at all levels, from frontline providers to managers and executives. This commitment establishes a "culture of safety." AHRQ's Patient Safety Network explains this topic further and provides links for more information on what is new in safety culture.

15. **Toolkit to Engage High-Risk Patients In Safe Transitions Across Ambulatory Settings**
    http://www.ahrq.gov/professionals/quality-patient-safety/hais/tools/ambulatory-care/safetransitions.html
    This toolkit developed by AHRQ is designed to help staff actively engage patients and their care partners to prevent errors during transitions of care.

16. **WHO Multi-Professional Patient Safety Curriculum Guide**
    https://www.who.int/patientsafety/education/mp_curriculum_guide/en/

    The World Health Organization developed this guide to assist in the teaching of patient safety in universities and schools in the fields of dentistry, medicine, midwifery, nursing, and pharmacy. It also supports the ongoing training of all healthcare professionals. The guide has two parts. Part A is a teacher's guide designed to introduce patient safety concepts to educators. It relates to building capacity for patient safety education, planning programs, and designing courses. Part B provides all-inclusive, ready-to-teach, topic-based patient safety courses that can be used as a whole or on a per topic basis. The curriculum covers 11 patient safety topics, each designed to feature a variety of ideas and methods for patient safety learning.

IX. Alphabetical Index of Resources

Official “Do Not Use” List Fact Sheet
Optimize the Care Team
Outcome Engenuity
Patient Care Experience Observation Exercise
Patient-Centered Primary Care Collaborative
The Patient Education Materials Assessment Tool (PEMAT) and User’s Guide
Patient Notification Toolkit
Patient Safety Primer: Culture of Safety
Patient Safety Primer: Medication Errors
Patient Safety Primer: Medication Reconciliation
Patient Safety Primer: Patient Safety in Ambulatory Care
Patient Safety Primer: Teamwork Training
Patient Safety Tools for Physician Practices
Plan-Do-Study-Act (PDSA) Steps and Worksheet
The Practice Facilitation Handbook: Training Modules for New Facilitators and Their Trainers
Predict and Anticipate Patient Needs
Provide Feedback to Frontline Staff
Quality Improvement Fundamentals Toolkit
RCA2: Improving Root Cause Analyses and Actions To Prevent Harm
Recalibrate the System by Working Down the Backlog
Reduce Scheduling Complexity
Regional Health eDecisions: A Guide to Connecting Health Information Exchange in Primary Care
Root Cause Analysis in Health Care: Tools and Techniques
Safety Huddle Results Collection Tool
SBAR Technique for Communication: A Situational Briefing Model
Shining a Light: Safer Health Care Through Transparency
Society to Improve Diagnosis in Medicine: Educational Resources
TeamSTEPPS® — Team Strategies and Tools to Enhance Performance and Patient Safety
Toolkit to Engage High-Risk Patients In Safe Transitions Across Ambulatory Settings
A Toolset for E-Prescribing Implementation in Physician Offices
Transitions of Care Checklist
WHO Multi-Professional Patient Safety Curriculum Guide
Will It Work Here?: A Decisionmaker’s Guide to Adopting Innovations
Workflow Assessment for Health IT Toolkit