

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

Purpose

This document contains references to Web sites that provide practical resources medical offices can use to implement changes to improve patient safety culture and patient safety. This resource list is not exhaustive, but is provided to give initial guidance to medical offices looking for information about patient safety initiatives. This document will be updated periodically.

How to Use This Resource List

Resources are listed in alphabetical order, organized by the composites assessed in the Agency for Healthcare Research and Quality (AHRQ) *Medical Office Survey on Patient Safety Culture* (Available at: <http://www.ahrq.gov/professionals/quality-patient-safety/patientsafetyculture/medical-office/index.html>), followed by general resources.

For easy access to the resources, keep the file open rather than printing it in hard copy because the Web site URLs are hyperlinked and cross-referenced resources are bookmarked within the document.

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.

Suggestions for tools you would like added to the list, questions about the survey, or requests for assistance can be addressed to: SafetyCultureSurveys@westat.com.

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[2015 National Patient Safety Goals: Ambulatory Care](#)
[AAAHC Institute Research and Toolkits](#)
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[AHRO Impact Case Studies](#), *NEW*
[AHRO Patient Centered Medical Home \(PCMH\) Resource Center](#)
[AHRO Patient Safety Education and Training Catalog](#)
[Always Events® Toolbox](#)
[Appoint a Safety Champion for Every Unit](#)
[Atlas of Integrated Behavioral Health Care Quality Measures](#)
[Aurora Health Care Medication List Toolkit](#)
[Balance Supply and Demand on a Daily, Weekly, and Long-Term Basis](#)
[Bilingual, Culturally Competent Managers Enhance Access to Prenatal Care for Migrant Women, Leading to Potential for Improved Birth Outcomes](#)
[CAHPS® Clinician & Group Survey](#)
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[Clinical Emergency: Are You Ready in Any Setting?](#)
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[E-Mail and Telephone Contact Replaces Most Patient Visits in Primary Care Practice, Leads to More Engaged Patients and Time Savings for Physicians](#)
[E-Mail Enhances Communication With and Access to Pediatrician for Patients and Families](#)
[Engaging Patients in Improving Ambulatory Care](#)
[Facts about the Official “Do Not Use” List](#), *NEW*
[Group Primary Care Visits Improve Outcomes for Patients With Chronic Conditions](#)
[Guide for Developing a Community-Based Patient Safety Advisory Council](#)
[Hand Hygiene in Healthcare Settings](#), *NEW*
[Health Assessments in Primary Care: A How-to Guide for Clinicians and Staff](#)
[Health Information Exchange \(HIE\) Evaluation Toolkit](#)
[The Health Information Security and Privacy Collaboration Toolkit](#)
[Health Information Technology Toolkit for Physician Offices](#)
[Health Literacy Universal Precautions Toolkit](#)
[Health Research & Educational Trust \(HRET\) Disparities Toolkit](#)
[Healthcare Provider Toolkit](#)
[Improve Workflow and Remove Waste](#)
[Improving Your Office Testing Process: a Toolkit for Rapid-Cycle Patient Safety and Quality Improvement](#)
[Information Technology \(IT\) Staff-Clinician Team Addresses IT Problems Affecting Providers and Patient Care, Leading to Increased System Usage and Efficiency](#)
[Institute for Patient- and Family-Centered Care](#)
[ISMP List of High-Alert Medications in Community/Ambulatory Healthcare](#)
[ISMP’s List of Confused Drug Names](#)
[Manage Panel Size and Scope of the Practice](#)
[Measure and Understand Supply and Demand](#)

[Medically Induced Trauma Support Services \(MITSS\)](#)
[Minnesota Alliance for Patient Safety Culture Road Map](#), *NEW*
[Monthly Text Messages Increase Compliance With Recommended Blood Glucose Testing in Medicaid Managed Care Enrollees With Diabetes](#)
[National Committee for Quality Assurance Patient-Centered Medical Home Recognition](#), *NEW*
[Nurse-Led Telephone Outreach More Than Doubles Pneumococcal Vaccination Rates for At-Risk Individuals](#)
[Onsite Nurses Manage Care Across Settings to Increase Satisfaction and Reduce Costs for Chronically Ill Seniors](#)
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[Revised Processes Related to Daily Opening Reduce Wait Times and Enhance Patient Satisfaction at Two Urban Clinics](#)
[SAFER Guides](#)
[Safety Feature Evaluation Forms](#), *NEW*
[Safety Huddle Results Collection Tool](#), *NEW*
[Saying Sorry](#)
[SBAR Technique for Communication: A Situational Briefing Model](#)
[Seven Steps to Patient Safety in General Practice](#)
[Six Sigma-Inspired Workflow Redesign Enhances Access to Care and Increases Patient Satisfaction, Visits, and Revenues in Obstetrics and Gynecology Residency Clinic](#)
[Society to Improve Diagnosis in Medicine: Educational Resources](#)
[TeamSTEPPS® Enhancing Safety for Patients With Limited English Proficiency Module](#)

[TeamSTEPPS® Primary Care Version](#)
[TeamSTEPPS® Readiness Assessment Tool](#)
[Time and Motion Studies Database](#)
[A Toolset for E-Prescribing Implementation in Physician Offices](#)
[TransforMEDSM Health Information Technology Resources](#)
[TransforMEDSM Medical Home Tools and Resources](#)
[Transitions of Care Checklist](#)
[Understand Just Culture, *NEW*](#)
[Using Change Concepts for Improvement](#)
[Voluntary, Anonymous, Nonpunitive System Leads to a Significant Increase in Reporting of Errors in Ambulatory Pediatric Practice](#)
[Voluntary Error Reporting Program Focusing on Systems Issues Increases Reporting and Contributes to Reduction in Liability Claims at Outpatient Clinic](#)
[Will It Work Here?: A Decisionmaker's Guide to Adopting Innovations](#)
[Workflow Assessment for Health IT Toolkit, *NEW*](#)

Resources by Composite

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

Composite 1. Teamwork

1. Clinical Emergency: Are You Ready in Any Setting?

<http://patientsafetyauthority.org/ADVISORIES/AdvisoryLibrary/2010/Jun7%282%29/Pages/52.aspx>

The Pennsylvania Patient Safety Authority is charged with taking steps to reduce and eliminate medical errors by identifying problems and recommending solutions that promote patient safety in various health care settings. This article discusses the issues associated with the location of clinical emergencies and strategies for facilities to achieve rapid response preparedness.

2. Patient Safety Primer: Teamwork Training

<http://psnet.ahrq.gov/primer.aspx?primerID=8>

Providing safe health care depends on highly trained individuals with disparate roles and responsibilities acting together in the best interests of the patient. The Agency for Healthcare Research and Quality's Patient Safety Network explains this topic further and provides links for more information on what is new in teamwork training.

3. TeamSTEPPS® Enhancing Safety for Patients With Limited English Proficiency Module

<http://www.ahrq.gov/professionals/education/curriculum-tools/teamstepps/lep/index.html>

Developed jointly by the Department of Defense (DoD) and the Agency for Healthcare Research and Quality, TeamSTEPPS® is a resource for training health care providers in better teamwork practices. The training package capitalizes on DoD's years of experience in medical and nonmedical team performance and AHRQ's extensive research in the fields of patient safety and health care quality. The TeamSTEPPS® Limited English Proficiency module is designed to help you develop and deploy a customized plan to train your staff in teamwork skills and lead a medical teamwork improvement initiative in your organization from initial concept development through to sustainment of positive changes.

4. TeamSTEPPS® Primary Care Version

<http://www.ahrq.gov/professionals/education/curriculum-tools/teamstepps/primarycare/index.html>

The Primary Care version of TeamSTEPPS® adapts the core concepts of the TeamSTEPPS® program to reflect the environment of primary care office-based teams. The examples, discussions, and exercises are tailored to the primary care environment.

5. TeamSTEPPS® Readiness Assessment Tool

<http://www.ahrq.gov/professionals/education/curriculum-tools/teamstepps/readiness/index.html>

Answering these questions can help your institution understand its level of readiness to initiate the TeamSTEPPS® program. You may find it helpful to have a colleague review your responses or to answer the questions with a larger group (e.g., senior leaders).

Composite 2. Patient Care Tracking/Followup

1. Group Primary Care Visits Improve Outcomes for Patients With Chronic Conditions

<https://innovations.ahrq.gov/profiles/group-primary-care-visits-improve-outcomes-patients-chronic-conditions?id=1890>

This featured profile is available on the Agency for Healthcare Research and Quality's Health Care Innovations Exchange Web site. An independent practice association in Northern California offers 60- to 90-minute group appointments for patients with chronic conditions such as diabetes, hypertension, and chronic obstructive pulmonary disease, as well as menopause, prenatal care, and pre-colonoscopy. These group appointments can enhance physician productivity, as they allow physicians to provide followup care and counseling to a greater number of patients (up to 15 patients are seen in an hour during the group visit, compared to 4 patients who can be seen each hour via regular appointments). A study conducted by the independent practice association found that diabetes patients receiving group care had better outcomes than those receiving usual care, including being more likely to meet goals related to blood glucose, blood pressure, and low density lipoprotein cholesterol levels.

2. Improving Your Office Testing Process: A Toolkit for Rapid-Cycle Patient Safety and Quality Improvement

<http://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/office-testing-toolkit/index.html>

This toolkit provides information and resources to help physicians' offices, clinics, and other ambulatory care facilities assess and improve the testing process in their offices.

3. Monthly Text Messages Increase Compliance With Recommended Blood Glucose Testing in Medicaid Managed Care Enrollees With Diabetes

<https://innovations.ahrq.gov/profiles/monthly-text-messages-increase-compliance-recommended-blood-glucose-testing-medicaid>

This featured profile is available on the Agency for Healthcare Research and Quality's Health Care Innovations Exchange Web site. A Medicaid managed care plan in Delaware uses cell phone text messaging to send members with type 2 diabetes monthly automated educational messages and reminders to make and keep appointments for blood glucose testing. In a pilot study, the percentage of participants receiving timely blood glucose tests rose from 52.3 percent at program inception to 70.5 percent 6 months later. This rate is much higher than the 45.4 percent compliance rate achieved by diabetic members not enrolled in the program. Based on this success, the organization expanded its use of text messaging to other diabetic patients and pregnant women and new mothers, sending them reminders about the need for prenatal and postnatal care.

4. Nurse-Led Telephone Outreach More Than Doubles Pneumococcal Vaccination Rates for At-Risk Individuals

<https://innovations.ahrq.gov/profiles/nurse-led-telephone-outreach-more-doubles-pneumococcal-vaccination-rates-risk-individuals>

This featured profile is available on the Agency for Healthcare Research and Quality's Health Care Innovations Exchange Web site. Kaiser Permanente Georgia contacts at-risk individuals to encourage those who have not received a vaccination or cancer screening to schedule an appointment for one. The program initially used nurses to call individuals in need of a pneumococcal vaccine; now, automated systems contact those in need of an influenza vaccine (with pneumococcal vaccines being promoted once the patient comes in for an appointment), mammogram, or Pap smear. A randomized controlled trial found that the nurse-led program more than doubled pneumococcal vaccination rates; data from the 2008 flu season suggest that the automated system significantly increased influenza vaccination rates.

5. Palliative Care Nurses in Primary Care Clinics Reduce Hospital Admissions, Increase Use of Hospice and Home Care for Patients Nearing End of Life

<https://innovations.ahrq.gov/profiles/palliative-care-nurses-primary-care-clinics-reduce-hospital-admissions-increase-use-hospice>

This featured profile is available on the Agency for Healthcare Research and Quality's Health Care Innovations Exchange Web site. A palliative care partnership between a hospice organization and an 11-location multispecialty group practice places palliative care nurses in primary care clinics to monitor frail, chronically ill elderly patients' medical and social care needs, coordinate community services, and discuss end-of-life issues. A study of 140 patients over age 65 who passed away between August 2004 and January 2006 revealed that 53 percent of patients who received palliative care were not admitted to the hospital 60 days prior to death, compared to just 28 percent of patients who did not receive palliative care.

6. Patient Notification Toolkit

<http://www.cdc.gov/injectionsafety/pntoolkit/index.html>

This toolkit provides guidance and resources to help organizations inform patients about infection control lapses.

7. Primary Care Practices Improve Patient Satisfaction With Communication of Outpatient Laboratory Test Results

<https://innovations.ahrq.gov/profiles/primary-care-practices-improve-patient-satisfaction-communication-outpatient-laboratory>

This featured profile is available on the Agency for Healthcare Research and Quality's Health Care Innovations Exchange Web site. Physicians at Partners Healthcare System enhanced the quality of patient-provider communication by making it easier for physicians to report laboratory and radiology results through an automated test result notification system. Sample screens from the interface have been published and are available from the innovator.

8. Real-Time Clinical Reminder System Improves Performance on Quality Measures

<https://innovations.ahrq.gov/profiles/real-time-clinical-reminder-system-improves-performance-quality-measures>

This featured profile is available on the Agency for Healthcare Research and Quality's Health Care Innovations Exchange Web site. Researchers at the University of Michigan Medical School transformed the way services are delivered at their family practice clinics using an electronic clinical reminder and tracking system designed to support evidence-based quality improvement efforts.

Composite 3. Organizational Learning

1. Decision Tree for Unsafe Acts Culpability

<http://www.ihi.org/resources/Pages/Tools/DecisionTreeforUnsafeActsCulpability.aspx> (requires free account setup and login)

The decision tree for unsafe acts culpability is a tool available for download from the Institute for Healthcare Improvement Web site. Staff can use this decision tree when analyzing an error or adverse event in an organization to help identify how human factors and systems issues contributed to the event. This decision tree is particularly helpful when working toward a nonpunitive approach in an organization.

2. 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 multi-disciplinary team approach, known as Root Cause Analysis - RCA - to study health care-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." Through the application of Human Factors Engineering (HFE) approaches, the National Center for Patient Safety aims to support human performance.

3. Patient Safety Tools for Physician Practices

<http://www.hret.org/quality/projects/pppsa.shtml>

The Health Research & Educational Trust (HRET) and its partners at the Institute for Safe Medication Practices and the Medical Group Management Association Center for Research have 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. Another tool, the Physician Practice Patient Assessment, helps physician practices evaluate their processes, clarify opportunities for improvement, measure progress over time, and facilitate dialogue among staff.

4. Plan-Do-Study-Act (PDSA) Worksheet

<http://www.ihl.org/resources/Pages/Tools/PlanDoStudyActWorksheet.aspx> (requires free account setup and login)

The Plan-Do-Study-Act (PDSA) Worksheet from the Institute for Healthcare Improvement is a useful tool for documenting a test of change. The 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).

5. 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 Agency for Healthcare Research and Quality 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 pre-session preparation for learners.

6. The PROMISES Project

http://www.brighamandwomens.org/research/depts/medicine/general_medicine/PBRN/PROMISES/default.aspx

This AHRQ-funded project, Proactive Reduction of Outpatient Malpractice: Improving Safety, Efficiency, and Satisfaction (PROMISES), created a collaborative learning network of

Massachusetts primary care practices and patient safety leaders. Program coaches visited 16 pilot primary care offices and worked directly with improvement teams to implement safe practices. The project also includes a report from physicians, malpractice insurers, and policy experts translating the hospital-based consensus statement, “When Things Go Wrong,” into clear recommendations for ambulatory adverse events. The Web site provides various materials, including recorded lectures, case study videos, and tools to assist individuals and teams with enhancing outpatient safety.

7. Quality Improvement Fundamentals Toolkit

http://www.leadingagency.org/home/assets/File/QI_Fundamentals_toolkit.pdf

This toolkit was developed by the Oklahoma Foundation for Medical Quality and can be used to help identify opportunities for improvement and develop improvement processes.

8. Using Change Concepts for Improvement

<http://www.ihi.org/resources/Pages/Changes/UsingChangeConceptsforImprovement.aspx>

(requires free account setup and login)

A change concept is a general notion or approach to change that has been found to be useful in developing specific ideas for changes that lead to improvement. This Institute for Healthcare Improvement Web page outlines change concepts such as error proofing, optimizing inventory, and improving workflow.

9. 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 decisionmaking and help decisionmakers determine whether an innovation would be a good fit or an appropriate stretch for their health care organization.

Composite 4. Overall Perceptions of Patient Safety

1. 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 health care workers and patients with a variety of resources, including guidelines for providers, patient empowerment materials, the latest technological advances in hand hygiene adherence measurement, frequently asked questions, and links to promotional and educational tools published by the World Health Organization, universities, and health departments.

2. Healthcare Provider Toolkit

<http://www.oneandonlycampaign.org/content/healthcare-provider-toolkit>

This toolkit will assist individuals and organizations with educating health care providers and patients about safe injection practices. Any health care provider that gives injections (in the form of medication, vaccinations, or other medical procedures) should be aware of safe injection practices. Partners of the Safe Injection Practices Coalition (SIPC) helped to create the materials in this toolkit and distribute these materials throughout their individual organizations.

3. Patient Safety Primer: Patient Safety in Ambulatory Care

<http://psnet.ahrq.gov/primer.aspx?primerID=16>

Despite the fact that the vast majority of health care 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.

4. Patient Safety Primer: Safety Culture

<http://psnet.ahrq.gov/primer.aspx?primerID=5>

The concept of safety culture originated outside health care 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.” The Agency for Healthcare Research and Quality’s Patient Safety Network explains this topic further and provides links for more information on what is new in safety culture.

Composite 5. Staff Training

1. AHRQ Patient Safety Education and Training Catalog

<http://psnet.ahrq.gov/pset/index.aspx>

The Agency for Healthcare Research and Quality’s Patient Safety Education and Training Catalog consists of patient safety programs currently available in the United States. The catalog, which is featured on AHRQ’s Patient Safety Network, offers an easily navigable database of patient safety education and training programs consisting of a robust collection of information each tagged for easy searching and browsing. The new database identifies a number of characteristics of the programs, including clinical area, program and learning objectives, evaluation measures, and cost. The clinical areas in the database align with the PSNet Collections.

2. Point-of-Care Complexity Assessment Helps Primary Care Clinicians Identify Barriers to Improved Health and Craft Integrated Care Plans

<https://innovations.ahrq.gov/profiles/point-care-complexity-assessment-helps-primary-care-clinicians-identify-barriers-improved>

This featured profile is available on the Agency for Healthcare Research and Quality's Health Care Innovations Exchange Web site. The Minnesota Complexity Assessment Method is used by clinicians to guide their assessment of potentially complex patients; to identify disease-related, social, and socioeconomic barriers to improved health; and to craft care plans to meet patient needs, often involving an expanded health care team and community support services. Feasibility testing and anecdotal reports from physicians and patients suggest that the approach is easy to use, promotes an enhanced understanding of the patient's situation, allows for more efficient and effective team conferences, improves the training experience of residents, and facilitates the development of customized care plans.

Cross-references to resources already described:

- Composite 1. Teamwork, #1 [Clinical Emergency: Are You Ready in Any Setting?](#)
- Composite 4. Overall Perceptions of Patient Safety, [Hand Hygiene in Healthcare Settings](#).

Composite 6. Owner/Managing Partner/Leadership Support for Patient Safety

1. Appoint a Safety Champion for Every Unit

<http://www.ihl.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 Institute for Healthcare Improvement Web site identifies tips for appointing a safety champion.

2. Conduct Patient Safety Leadership WalkRounds™

<http://www.ihl.org/resources/Pages/Changes/ConductPatientSafetyLeadershipWalkRounds.aspx>

(requires free account setup and login)

Senior leaders can demonstrate their commitment to safety and learn about the safety issues in their own organization by making regular rounds to discuss safety issues with the frontline staff. This Institute for Healthcare Improvement Web site discusses the benefits of management making regular rounds and provides links to tools available for download.

3. Safety Huddle Results Collection Tool

<http://www.ihi.org/resources/Pages/Tools/SafetyHuddleResultsCollectionTool.aspx> (requires free account setup and login)

Safety Briefings increase safety awareness among frontline staff and help an organization develop a culture of safety. To determine whether Safety Briefings are accomplishing these goals, organizations need to collect data to monitor progress. Iowa Health System tested the use of Safety Briefings (which it calls "Safety Huddles") to increase safety awareness and designed a tool to assist its staff with data collection during those tests.

Composite 7. Communication About Error

1. Call to Action: Safeguarding the Integrity of Healthcare Quality and Safety Systems

http://www.nahq.org/uploads/NAHQ_call_to_action_FINAL.pdf

The National Association for Healthcare Quality *Call to Action: Safeguarding the Integrity of Healthcare Quality and Safety Systems* provides best practices to enhance quality, improve ongoing safety reporting and protect staff. It addresses accountability, protection of those who report quality and safety concerns, and accurate reporting and response.

2. Patient Safety and the “Just Culture”

http://www.health.ny.gov/professionals/patients/patient_safety/conference/2007/docs/patient_safety_and_the_just_culture.pdf

This presentation by David Marx defines just culture, the safety task, the just culture model, and statewide initiatives in New York.

3. Provide Feedback to Front-Line Staff

<http://www.ihi.org/resources/Pages/Changes/ProvideFeedbacktoFrontLineStaff.aspx> (requires free account setup and login)

Feedback to the front-line 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 how to communicate feedback.

4. Saying Sorry

<http://www.nhsla.com/Claims/Documents/Saying%20Sorry%20-%20Leaflet.pdf>

Although victims of adverse events have clearly expressed their preferences for full error disclosure, most physicians remain uncomfortable with disclosing and apologizing for errors. This leaflet offers information to help clinicians understand the value of effective apologies along with tips for organizations to support open disclosure efforts.

5. Understand Just Culture

http://www.ahrq.gov/professionals/education/curriculum-tools/cusptoolkit/videos/07a_just_culture/index.html

The Agency for Healthcare Research and Quality offers free resources on developing a "just culture" and applying strategies of the Comprehensive Unit-based Safety Program (CUSP). The Apply CUSP module of the CUSP toolkit presents the principles of a just culture, a nonpunitive environment that encourages reporting of adverse events. Included in the module is this video on understanding just culture.

6. Voluntary, Anonymous, Nonpunitive System Leads to a Significant Increase in Reporting of Errors in Ambulatory Pediatric Practice

<https://innovations.ahrq.gov/profiles/voluntary-anonymous-non-punitive-system-leads-significant-increase-reporting-errors>

This featured profile is available on the Agency for Healthcare Research and Quality's Health Care Innovations Exchange Web site. A hospital's ambulatory pediatrics department developed a voluntary, anonymous, and nonpunitive medical error reporting system that includes a quick-response team to review reports and enact interventions to prevent recurrences. The program significantly increased the reporting of medical errors and near misses, leading to the implementation of numerous changes designed to improve safety.

7. Voluntary Error Reporting Program Focusing on Systems Issues Increases Reporting and Contributes to Reduction in Liability Claims at Outpatient Clinic

<https://innovations.ahrq.gov/profiles/voluntary-error-reporting-program-focusing-systems-issues-increases-reporting-and>

This featured profile is available on the Agency for Healthcare Research and Quality's Health Care Innovations Exchange Web site. A hospital outpatient clinic developed a confidential, voluntary error reporting system that focuses on identifying faulty systems and error-prone areas — instead of individual mistakes — to improve processes and prevent future mistakes. A simple taxonomy of errors was created to track the types of issues that were identified. Since implementation of the system, the number of error reports has increased six fold (from 20 to 120), while the number of liability claims has declined. Although there is no direct evidence linking the system to the reduction in liability claims, program leaders believe it has contributed to the decline.

Cross-reference to resource already described:

- Composite 3. Organizational Learning, [Decision Tree for Unsafe Acts Culpability](#).

Composite 8. Communication Openness

1. E-Mail Enhances Communication With and Access to Pediatrician for Patients and Families

<https://innovations.ahrq.gov/profiles/e-mail-enhances-communication-and-access-pediatrician-patients-and-families>

This featured profile is available on the Agency for Healthcare Research and Quality's Health Care Innovations Exchange Web site. A pediatric subspecialist offered the families of his patients the opportunity to contact him via e-mail, with formal guidelines established with respect to the appropriate use of the system (e.g., content, length, response time). More than 90 percent of families offered the service enrolled, with approximately 40 percent using the service during a 2-year period. Families using the service reported enhanced communication with and access to the pediatrician. The physician found that use of the e-mail service saved him time versus answering the same inquiries via telephone. In addition, over time, the program has engaged more teenagers to contact the doctor directly using electronic communication.

2. SBAR Technique for Communication: A Situational Briefing Model

<http://www.ihl.org/resources/Pages/Tools/SBARTechniqueforCommunicationASituationalBriefingModel.aspx> (requires free account setup and login)

The SBAR (Situation-Background-Assessment-Recommendation) technique provides a framework for communication between members of the health care team about a patient's condition. This downloadable tool from the Institute for Healthcare Improvement 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 that a provider can use to organize information in preparing to communicate with a physician about a critically ill patient.

Cross-reference to resource already described:

- Composite 2. Patient Care Tracking/Followup, #7 [Primary Care Practices Improve Patient Satisfaction With Communication of Outpatient Laboratory Test Results.](#)

Composite 9. Patient Safety and Quality Issues

Access to Care

1. Balance Supply and Demand on a Daily, Weekly, and Long-Term Basis

<http://www.ihl.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 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.ihl.org/resources/Pages/Changes/DecreaseDemandforAppointments.aspx> (requires free account setup and login)

One key way for a health care 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 Institute for Healthcare Improvement 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.ihl.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 Institute for Healthcare Improvement Web page contains information on how to measure and understand supply and demand.

4. Open Scheduling and Related Strategies Lead to Zero Wait Time for Appointments and Few No Shows at Family Practice

<https://innovations.ahrq.gov/profiles/open-scheduling-and-related-strategies-lead-zero-wait-time-appointments-and-few-no-shows>

This featured profile is available on the Agency for Healthcare Research and Quality's Health Care Innovations Exchange Web site. A five-physician family practice in the suburbs of Indianapolis ensures maximum patient access by providing same-day appointments through an open access scheduling system, extended hours, direct telephone access to physicians after hours, electronic visits, and other strategies. As a result, patients can get an appointment without any delay (in contrast to the typical practice where patients often must wait 30 to 60 days for an appointment), and the practice enjoys a no-show rate of only 4 percent.

5. Optimize the Care Team

<http://www.ihl.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 flow of work. This Institute for Healthcare Improvement Web page contains information on decreasing demand for appointments.

6. Reduce Scheduling Complexity

<http://www.ihl.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 Institute for Healthcare Improvement Web page contains information on how to reduce scheduling complexity.

7. Six Sigma-Inspired Workflow Redesign Enhances Access to Care and Increases Patient Satisfaction, Visits, and Revenues in Obstetrics and Gynecology Residency Clinic

<https://innovations.ahrq.gov/profiles/six-sigma-inspired-workflow-redesign-enhances-access-care-and-increases-patient>

This featured profile is available on the Agency for Healthcare Research and Quality's Health Care Innovations Exchange Web site. A hospital's obstetrics and gynecology residency training clinic used Six Sigma methodologies to identify and address inefficiencies in workflow processes related to patient flow and staffing. Through redeployment of staff, revised scheduling processes, and other changes, the program significantly reduced waiting times for appointments and the length of clinic visits. The program also increased patient satisfaction and clinic volume and revenues.

Patient Identification

1. 2015 National Patient Safety Goals: Ambulatory Care

http://www.jointcommission.org/assets/1/6/2015_AHC_NPSG_ER.pdf

The purpose of the Joint Commission Ambulatory Care National Safety Goals is to improve patient safety in an ambulatory setting by focusing on specific goals.

Charts and Medical Records

1. Electronic Medical Record-Facilitated Workflow Changes Enhance Quality and Efficiency, Generating Positive Return on Investment in Small Pediatrics Practice

<https://innovations.ahrq.gov/profiles/electronic-medical-record-facilitated-workflow-changes-enhance-quality-and-efficiency>

This featured profile is available on the Agency for Healthcare Research and Quality's Health Care Innovations Exchange Web site. Four Seasons Pediatrics, a three-physician group in upstate New York, redesigned its workflow, reduced staffing costs, and enhanced quality of care while adopting an electronic medical record. The group also achieved a positive return on investment within 2.5 years, earning financial rewards through the Bridges to Excellence program and other pay-for-performance programs.

2. 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 health care organizations assess their readiness, plan, select, implement, make effective use of, and exchange important information about the clients you serve. The toolkit contains numerous resources, including tools for telehealth, health information exchange, and personal health records.

3. TransforMEDSM Health Information Technology Resources

<http://transformed.com/resources/HIT.cfm>

TransforMEDSM is a subsidiary of the American Academy of Family Physicians. This Web site features health information technology resources on the following topics: electronic health record, electronic prescribing, disease and population management software/registries, evidence-based decision support, and Web site/patient/portal.

Cross-reference to resource already described:

- Composite 2. Patient Care Tracking/Followup, #8 [Real-Time Clinical Reminder System Improves Performance on Quality Measures](#).

Medical Equipment

1. Safety Feature Evaluation Forms

<http://www.tdict.org/evaluation2.html>

The Training for Development of Innovative Control Technologies (TDICT) Project is a collaborative effort of line health care workers, product designers, and industrial hygienists dedicated to preventing exposure to blood through better design and evaluation

of medical devices and equipment. In conjunction with line health care workers, TDICT has developed criteria for evaluation of several medical devices.

Cross-reference to resource already described:

- Composite 1. Teamwork, #1 [Clinical Emergency: Are You Ready in Any Setting?](#)

Medication

1. Aurora Health Care Medication List Toolkit

<http://www.consumersadvancingpatientsafety.org/programs/partners-in-safety/aurora-health-care-medication-list-toolkit/>

This toolkit is designed to help health care organizations create an accurate medication list in the outpatient setting through a patient-centered approach.

2. ISMP List of High-Alert Medications in Community/Ambulatory Healthcare

<http://www.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.

3. ISMP's List of Confused Drug Names

<http://www.ismp.org/Tools/Confused-Drug-Names.aspx>

Drawing on information gathered from the ISMP Medication Errors Reporting Program, this Web page provides a comprehensive list of commonly confused medication names, including look-alike and sound-alike name pairs. Drug name confusion can easily lead to medication errors, and the ISMP has recommended interventions such as the use of tall man lettering in order to prevent such errors.

4. Patient Safety Primer: Medication Reconciliation

<http://www.psnet.ahrq.gov/primer.aspx?primerID=1>

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. The Agency for Healthcare Research and Quality's Patient Safety Network explains this topic further and provides links for more information on what is new in medication reconciliation.

5. 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 your practice 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 decisionmaking, such as surveys to determine whether your 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 (SIDM) features educational resources for trainees, practitioners, and educators on clinical reasoning, critical thinking, and systems factors that underlie diagnostic error, and strategies to improve diagnostic performance.

Cross-references to resource 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](#).

Composite 10. Office Processes and Standardization

1. Create Contingency Plans

<http://www.ihl.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. Information Technology (IT) Staff-Clinician Team Addresses IT Problems Affecting Providers and Patient Care, Leading to Increased System Usage and Efficiency

<https://innovations.ahrq.gov/profiles/information-technology-it-staff-clinician-team-addresses-it-problems-affecting-providers>

This featured profile is available on the Agency for Healthcare Research and Quality's Health Care Innovations Exchange Web site. Mayo Clinic started an initiative involving clinicians and systems engineering analysts who worked together to better customize and align the clinic's information system (Mayo Integrated Clinical Systems, or MICS) to support providers and patient care processes. As a key part of the team's work, staff shadowed providers, observing their interactions with patients and their use of information technology for managing information. The shadowing process led to direct feedback and open dialogue between clinical and project staff, which served as a catalyst for system enhancements, training initiatives, and other improvements designed to enhance work processes, efficiency, and patient care.

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.

Cross-references to resources already described:

- Composite 1. Teamwork, #1 [Clinical Emergency: Are You Ready in Any Setting?](#)
- Composite 2. Patient Care Tracking/Followup, #7 [Primary Care Practices Improve Patient Satisfaction With Communication of Outpatient Laboratory Test Results.](#)
- Composite 9. Patient Safety and Quality Issues, Charts and Medical Records, #1 [Electronic Medical Record-Facilitated Workflow Changes Enhance Quality and Efficiency, Generating Positive Return on Investment in Small Pediatrics Practice.](#)

Composite 11. Information Exchange With Other Settings

1. Facts about the Official "Do Not Use" List

http://www.jointcommission.org/assets/1/18/dnu_list.pdf

In 2001, The Joint Commission issued a Sentinel Event Alert on the subject of medical abbreviations, and just one year later, its Board of Commissioners approved a National Patient Safety Goal requiring accredited organizations to develop and implement a list of abbreviations not to use. In 2004, The Joint Commission created its "do not use" list of abbreviations as part of the requirements for meeting that goal. In 2010, NPSG.02.02.01 was integrated into the Information Management standards as elements of performance 2 and 3 under IM.02.02.01.

2. Health Information Exchange (HIE) Evaluation Toolkit

<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 evaluation of 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 health care quality and safety.

3. The 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 (HIE). It was developed as part of the Agency for Healthcare Research and Quality (AHRQ) and Office of the National Coordinator for Health Information Technology (ONC) joint-funded Health Information Security and Privacy Collaboration (HISPC) project.

4. Onsite Nurses Manage Care Across Settings to Increase Satisfaction and Reduce Costs for Chronically Ill Seniors

<https://innovations.ahrq.gov/profiles/onsite-nurses-manage-care-across-settings-increase-satisfaction-and-reduce-cost-chronically>

This featured profile is available on the Agency for Healthcare Research and Quality's Health Care Innovations Exchange Web site. Specially trained nurses work with primary care physicians in their offices to improve care for seniors with multiple chronic illnesses by coordinating care, facilitating transitions in care, and acting as the patient's advocate across health care and social settings. Nurses use an electronic health record and a variety of established methods, including disease management, case management, transitional care, self-management, lifestyle modification, caregiver education and support, and geriatric evaluation and management.

5. 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 guide, developed by the Agency for Healthcare Research and Quality (AHRQ), 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 (EHR) 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 is 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 decisionmaking and the

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.

6. 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.

Cross-reference to resources already described:

- Composite 2. Patient Care Tracking/Followup, #5 [Palliative Care Nurses in Primary Care Clinics Reduce Hospital Admissions, Increase Use of Hospice and Home Care for Patients Nearing End of Life.](#)

Composite 12. Work Pressure and Pace

1. E-Mail and Telephone Contact Replaces Most Patient Visits in Primary Care Practice, Leads to More Engaged Patients and Time Savings for Physicians

<https://innovations.ahrq.gov/profiles/e-mail-and-telephone-contact-replaces-most-patient-visits-primary-care-practice-leads-more>

This featured profile is available on the Agency for Healthcare Research and Quality's Health Care Innovations Exchange Web site. Based on the belief that more than one-half of primary care office visits are unnecessary, GreenField Health relies heavily on e-mail and telephone communications for most patient contacts, which in turn frees staff to see patients who need in-person care in a timely manner. Anecdotal reports indicate that this approach more fully engages patients in their care and decisionmaking, enables better care management, and saves physician and staff time.

2. Manage Panel Size and Scope of the Practice

<http://www.ihl.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 do today's work today. This Institute for Healthcare Improvement Web page also includes links that contain more specific information and strategies for managing panel size and the scope of the practice.

3. Predict and Anticipate Patient Needs

<http://www.ihl.org/resources/Pages/Changes/PredictandAnticipatePatientNeeds.aspx> (requires free account setup and login)

To ensure that patient needs are met and that patients flow smoothly through the clinic process, staff look ahead on the schedule to identify patient needs for a given day or week. This Institute for Healthcare Improvement Web site includes links to more specific information and strategies on predicting and anticipating patient needs.

4. Recalibrate the System by Working Down the Backlog

<http://www.ihl.org/resources/Pages/Changes/RecalibratetheSystembyWorkingDowntheBacklog.aspx> (requires free account setup and login)

This Institute for Healthcare Improvement 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.

Cross-reference to resource already described:

- Composite 9. Patient Safety and Quality Issues, Access to Care, #7 [Six Sigma-Inspired Workflow Redesign Enhances Access to Care and Increases Patient Satisfaction, Visits, and Revenues in Obstetrics and Gynecology Residency Clinic.](#)

Overall Ratings on Quality and Patient Safety

Patient Centered

1. AHRQ Patient Centered Medical Home (PCMH) Resource Center

<https://pcmh.ahrq.gov/page/tools-resources>

The Agency for Healthcare Research and Quality recognizes that revitalizing the Nation's primary care system is foundational to achieving high-quality, accessible, efficient health care 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 Agency for Healthcare Research and Quality initiative to support the assessment of consumers' experiences with health care. This Web site 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. Health Literacy Universal Precautions Toolkit

<http://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/literacy-toolkit/index.html>

The Agency for Healthcare Research and Quality commissioned the University of North Carolina at Chapel Hill to develop and test this Health Literacy Universal Precautions Toolkit. The toolkit offers primary care practices a way to assess their services for health literacy considerations, raise awareness of the entire staff, and work on specific areas.

4. Institute for Patient- and Family-Centered Care

<http://www.ipfcc.org/tools/downloads.html>

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

5. Patient Care Experience Observation Exercise

<http://www.ihl.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 rather than assumptions that may be made by those 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 nonjudgmental way, using the observations to inform improvements to the care experience.

6. 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 Web site offers a variety of Webinars related to Accountable Care Organizations, care coordination, education and training, eHealth, employers, and transformation.

7. 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

1. Placing Mental Health Specialists in Primary Care Settings Enhances Patient Engagement, Produces Favorable Results Relative to Evidence-Based Care

<https://innovations.ahrq.gov/profiles/placing-mental-health-specialists-primary-care-settings-enhances-patient-engagement>

This featured profile is available on the Agency for Healthcare Research and Quality's Health Care Innovations Exchange Web site. An integrated care program places mental and behavioral health specialists in more than 50 primary care locations to treat patients age 65 years and over with depression or anxiety and those who engage in risky alcohol use. The model uses comprehensive assessments and promotes coordinated care planning and treatment based on chronic disease management principles and established treatment guidelines.

Timely

1. Revised Processes Related to Daily Opening Reduce Wait Times and Enhance Patient Satisfaction at Two Urban Clinics

<https://innovations.ahrq.gov/profiles/revised-processes-related-daily-opening-reduce-wait-times-and-enhance-patient-satisfaction>

Urban Health Plan, a federally qualified health center providing care to underserved communities in the South Bronx, reformed operational processes and aspects of physical design in two clinics to ensure that they were truly prepared to begin work upon opening in the morning. These changes, referred to as the First Hour project, were designed to improve the efficiency of patient care throughout the day. The program has reduced wait times, increased patient satisfaction, and improved patient-provider interactions. It is featured on the Agency for Healthcare Research and Quality's Health Care Innovations Exchange.

Cross-reference to resource already described:

- Composite 9. Patient Safety and Quality Issues, [Access to Care](#).

Efficient

1. Adoption of Rapid Cycle Improvement Process From Toyota Increases Efficiency and Productivity at Community Health Clinics

<https://innovations.ahrq.gov/profiles/adoption-rapid-cycle-improvement-process-toyota-increases-efficiency-and-productivity>

Denver Community Health Services, the primary care clinic component of Denver Health (Colorado's primary safety net institution), uses the Toyota "Lean" rapid cycle process improvement system to enhance efficiency in eight Federally Qualified Health Centers. As a result of these improvements, the clinic has cut patient registration time in half, increased provider productivity by 25 percent, reduced patient cycle time and the patient no-show rate, and increased revenues by approximately \$3.5 million.

2. Improve Workflow and Remove Waste

<http://www.ihl.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 Institute for Healthcare Improvement Web page provides information about how to improve work flow.

3. Time and Motion Studies Database

<http://healthit.ahrq.gov/health-it-tools-and-resources/time-and-motion-studies-database>

Measuring the impacts of technology on clinical tasks often involves performing a time and motion study. In a time and motion study, observers follow clinicians and record how long specific tasks, such as signing a medication prescription or listening to a patient describe her symptoms, take to complete. Researchers at Partners Healthcare have created a tool to help others accurately capture time and motion study data. The tool, a Microsoft Access database, allows observers to record time and motion data and store them for analysis. Partners has also created a user's guide for this new tool and published a journal article that provides a case example of how the tool can be used to evaluate the effectiveness of a health information technology.

Equitable

1. 2014 National Healthcare Quality and Disparities Report: Chartbook on Patient Safety

<http://www.ahrq.gov/research/findings/nhqdr/2014chartbooks/patientsafety/>

This Patient Safety chartbook is part of a family of documents and tools that support the National Healthcare Quality and Disparities Report (QDR). This chartbook includes a summary of trends across measures of patient safety from the QDR and figures illustrating select measures of patient safety. A PowerPoint version is also available that users can download for presentations.

2. Bilingual, Culturally Competent Managers Enhance Access to Prenatal Care for Migrant Women, Leading to Potential for Improved Birth Outcomes

<https://innovations.ahrq.gov/profiles/bilingual-culturally-competent-managers-enhance-access-prenatal-care-migrant-women-leading>

This featured profile is available on the Agency for Healthcare Improvement's Health Care Innovations Exchange Web site. The Migrant Clinicians Network Prenatal Care Program seeks to ensure continuity of care for expectant mothers who begin prenatal care in one location and move for employment purposes during their pregnancy. Bilingual, culturally competent staff link these migrant patients with prenatal services and manage their medical records throughout the pregnancy. While the health outcomes of participants have not been formally evaluated, postimplementation data suggest that the program is enhancing access to prenatal services and continuity of care in a population that has no other way to access such services.

3. 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.

4. Plan-Funded Team Coordinates Enhanced Primary Care and Support Services to At-Risk Seniors, Reducing Hospitalizations and Emergency Department Visits

<https://innovations.ahrq.gov/profiles/plan-funded-team-coordinates-enhanced-primary-care-and-support-services-risk-seniors>

This featured profile is available on the Agency for Healthcare Research and Quality's Health Care Innovations Exchange Web site. Commonwealth Care Alliance developed a health plan that provides low-income, dual eligible, elderly enrollees in Massachusetts with a primary care team made up of a physician, nurse practitioner, and geriatric specialist who work out of the enrollee's primary care clinic.

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 health care. 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 policymakers, health systems, clinicians, academicians, and other professionals.

3. Always Events[®] Toolbox

<http://alwaysevents.pickerinstitute.org/?p=1019>

The Picker Institute provides tools and strategies to assist health care professionals in implementing Always Events[®] initiatives and meeting their patient- and family-centered care goals. Always Events[®] are defined as “those aspects of the patient and family experience that should always occur when patients interact with health care professionals and the delivery system.” These tools and strategies were developed by numerous health care professionals from across the country as they implemented initiatives designed to enhance the care provided to patients through the implementation of Always Events[®].

4. Atlas of Integrated Behavioral Health Care Quality Measures

<http://integrationacademy.ahrq.gov/atlas>

This guide, for primary health care practitioners, researchers, and measurement experts, provides measures and practices for integrating behavioral health care 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 health care
- 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 CAHPS[®] (Consumer Assessment of Healthcare Providers and Systems) 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 Toolkits are intended to be small, self-contained resource modules for training and application. The available toolkits include: Briefs and Huddles, Debriefs, Patient Falls Reduction, Patient Activation Reference Guide, Professional Conduct, and Situation, Background, Assessment, Recommendation (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 health care improvement that have been implemented in Maine, Oregon, and Humboldt County, California.

8. Guide for Developing a Community-Based Patient Safety Advisory Council

<http://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/patient-safety-resources/resources/patient-safety-advisory-council/patient-safety-advisory-council.pdf>

The *Guide for Developing a Community-Based Patient Safety Advisory Council* provides information and guidance to empower individuals and organizations to develop a community-based advisory council. These councils involve patients, consumers, and a variety of practitioners and professionals from health care and community organizations to drive change for patient safety through education, collaboration, and consumer engagement.

9. Health Assessments in Primary Care: A How-to Guide for Clinicians and Staff

<http://www.ahrq.gov/professionals/prevention-chronic-care/improve/system/health-assessments/index.html>

The purpose of this guide is to provide a framework and practical, evidenced-based guidance for primary care teams to adopt and successfully implement health assessments in primary care practices. This guide is designed to be used by a team of clinicians and staff in a practice.

10. Medically Induced Trauma Support Services (MITSS)

<http://www.mitsstools.org/tool-kit-for-staff-support-for-healthcare-organizations.html>

Medically Induced Trauma Support Services (MITSS), Inc., a nonprofit organization whose mission is “to support healing and restore hope” to patients, families, and clinicians who have been affected by an adverse medical event, developed a toolkit for clinician support. MITSS also provides an organizational assessment tool and a comprehensive work plan.

11. Minnesota Alliance for Patient Safety Culture Road Map

<http://mnpatientsafety.org/Culture-Road-Map>

The Minnesota Alliance for Patient Safety, a partnership among the Minnesota Hospital Association, Minnesota Medical Association, Minnesota Department of Health, and more than 50 other public and private health care organizations, has developed a safety culture road map for organizations working toward a culture of safety.

12. 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 PCMH is a way to organize 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.

13. Patient Safety Primer: Medication Errors

<http://psnet.ahrq.gov/primer.aspx?primerID=23>

A growing evidence base supports specific strategies to prevent adverse drug events (ADEs). The Agency for Healthcare Research and Quality'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.

14. Quality Improvement Savings Tracker Worksheet

<http://www.ihl.org/resources/Pages/Tools/QISavingsTrackerWorksheet.aspx> (requires free account setup and login)

The Quality Improvement Savings Tracker Worksheet may be used throughout the organization to track cost savings associated with waste reduction efforts and to adjust for annual changes. The tool enables the organization to compare expenses in the area of interest to expenses incurred the year prior and adjust for wage increases and productivity/volume changes. The organization can then use the worksheet to track any investments made with the savings accrued.

15. SAFER Guides

<http://www.healthit.gov/policy-researchers-implementers/safer>

SAFER guides, released by the Office of the National Coordinator for Health Information Technology (ONC) at the Department of Health and Human Services, are a suite of tools designed to help health care providers and the organizations that support them assess and optimize the safety and safe use of electronic health information technology products, such as

electronic health records (EHRs). Each SAFER Guide addresses a critical area associated with the safe use of EHRs through a series of self-assessment checklists, practice worksheets, and recommended practices. Each SAFER Guide has extensive references and is available as a downloadable PDF and as an interactive Web-based tool.

Areas addressed include:

- High Priority Practices
- Organizational Responsibilities
- Patient Identification
- Computerized Physician Order Entry (CPOE) With Decision Support
- Test Results Review and Followup
- Clinician Communication
- Contingency Planning
- System Interfaces
- System Configuration

16. Seven Steps to Patient Safety in General Practice

<http://www.nrls.npsa.nhs.uk/resources/collections/seven-steps-to-patient-safety/?entryid45=61598>

This best practice guide from the National Patient Safety Agency alerts general practices to the seven steps through which they can work in order to safeguard their patients. It offers various exercises to develop safety strategies and tips for safe care in general practice. Alongside each step is a set of activities that can be taken to develop policies, strategies, and action plans. There are also practical hints and techniques that can be used to promote quality care.

17. TransforMEDSM Medical Home Tools and Resources

<http://transformed.com/resources.cfm>

TransforMEDSM is a subsidiary of the American Academy of Family Physicians. TransforMEDSM has assembled hundreds of the best and most current online resources related to the modules of the TransforMEDSM Patient-Centered Medical Home model for use as self-education tools, quick reference guides, and templates.