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 homes 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

General resources are listed first, in alphabetical order, followed by resources organized by the dimensions assessed in the Agency for Healthcare Research and Quality (AHRQ) *Medical Office Survey on Patient Safety Culture* (available at http://www.ahrq.gov/qual/patientsafetyculture).

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@ahrq.hhs.gov.

Agency for Healthcare Research and Quality
Advancing Excellence in Health Care • www.ahrq.gov

Table of Contents

Alphabetical Index of Resources

General Resources

1. **2010 National Patient Safety Goals: Ambulatory Care**
    www.jointcommission.org/patientsafety/nationalpatientsafetygoals/

    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. This Web site, which contains a link to the latest goals, includes improvements emanating from the Standards Improvement Initiative. In addition, the site has information on the new numbering system and minor language changes for consistency.

2. **30 Safe Practices for Better Health Care Fact Sheet**
    www.innovations.ahrq.gov/content.aspx?id=765

    This fact sheet is featured on AHRQ's Health Care Innovations Exchange Web site. The National Quality Forum has identified 30 safe practices that evidence shows can work to reduce or prevent adverse events and medication errors. These practices can be universally adopted by all health care settings to reduce the risk of harm to patients. This tool also provides background information about the National Quality Forum, as well as links to a report providing more detailed information about the 30 Safe Practices.

3. **AHRQ Health Care Innovations Exchange**
    www.innovations.ahrq.gov/

    AHRQ's Health Care Innovations Exchange is a comprehensive program designed to accelerate the development and adoption of innovations in health care delivery. This program supports the Agency's mission to improve the safety, effectiveness, patient centeredness, timeliness, efficiency, and equity of care. It emphasizes reducing disparities in health care and health among racial, ethnic, and socioeconomic groups. The Innovations Exchange has the following components:

    *   Searchable innovations and attempts
    *   Searchable QualityTools
    *   Learning opportunities
    *   Networking opportunities

4. **AHRQ Medical Errors and Patient Safety**
    www.ahrq.gov/qual/errorsix.htm

    The AHRQ Medical Errors and Patient Safety Web site provides links to various resources and tools for promoting patient safety in the following categories:

    *   Tips for Consumers and Patients
    *   Background
    *   Communication and Teamwork
    *   Design and Working Conditions
    *   Implementation and Transformation
    *   Patient Safety Organizations

- Patient Safety Research and Funding Opportunities
- Tools and Techniques

5. **AHRQ Patient Safety Network**
   www.psnet.ahrq.gov/

   AHRQ Patient Safety Network (PSNet) is a national Web-based resource featuring the latest news and essential resources on patient safety. The site offers weekly updates of patient safety literature, news, tools, and meetings ("What's New"), and a vast set of carefully annotated links to important research and other information on patient safety ("The Collection"). Supported by a robust patient safety taxonomy and Web architecture, PSNet provides searching and browsing capability and allows users to customize the site around their interests (My PSNet). It also is tightly coupled with AHRQ's WebM&M, the popular monthly journal that features user-submitted cases of medical errors, expert commentaries, and perspectives on patient safety.

6. **CAHPS® Improvement Guide**
   www.cahps.ahrq.gov/QIguide/content/interventions/default.aspx

   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. Over time, this guide will be updated to include new improvement interventions and offer additional resources.

7. **Chasing Zero: Winning the War on Health Care Harm**
   http://discoveryhealthcme.discovery.com/zero/media/program.html

   A near-fatal medical error almost cost the lives of twins born to actor Dennis Quaid and his wife. This real-life event inspires a new patient education documentary featuring the Quaid family's personal ordeal, along with stories of other families who faced medical errors. It also features experts who are leading efforts to help health care providers reduce medical errors and improve patient safety outcomes.

8. **The Commonwealth Fund**
   www.commonwealthfund.org/

   The Commonwealth Fund is a private foundation that aims to promote a high-performing health care system that achieves better access, improved quality, and greater efficiency. The organization focuses on society's most vulnerable populations, including low-income people, uninsured people, minority groups, young children, and older adults. The Commonwealth Fund provides information on a variety of health care topics, as well as free publications and innovations and tools for improving health care.

9. Consumers Advancing Patient Safety
   www.patientsafety.org/

   Consumers Advancing Patient Safety (CAPS) is a consumer-led nonprofit organization aimed at providing a collective voice for individuals, families, and healers who want to prevent harm in health care encounters through partnership and collaboration. CAPS features a transitions toolkit (available at www.patientsafety.org/page/142046/) titled "Taking Charge of Your Healthcare: Your Path to Being an Empowered Patient."

10. Department of Defense Patient Safety Program
   http://health.mil/dodpatientsafety

   The Department of Defense Patient Safety Program is a comprehensive program designed to establish a culture of patient safety and quality within the Military Health System (MHS). The program encourages a systems approach to create a safer patient environment; engages MHS leadership; promotes collaboration across all three services; and fosters trust, transparency, teamwork, and communication.

11. Innovations in Planned Care
   www.ihi.org/IHI/Results/WhitePapers/InnovationsinPlanned+CareWhitePaper.htm

This is a white paper on the Institute for Healthcare Improvement (IHI) Web site that identifies challenges facing the current health care system and introduces a new design for the delivery of primary care.

12. Institute for Healthcare Improvement
   www.ihi.org/ihi

   IHI is a reliable source of energy, knowledge, and support for an ongoing campaign to improve health care worldwide. IHI helps accelerate change in health care by cultivating promising concepts for improving patient care and turning those ideas into action.

13. Institute for Safe Medication Practices
   www.ismp.org

   The Institute for Safe Medication Practices offers a wide variety of free educational materials and services on their Web site:

   - Special Medication Hazard Alerts
   - Searchable information on a wide variety of medication safety topics
   - Answers to frequently asked questions about medication safety
   - Food and Drug Administration Patient Safety Videos
   - Pathways for medication safety tools
   - White papers on bar-coding technology and electronic prescribing
   - A monitored message board to share questions, answers, and ideas

14. Joint Commission: Patient Safety
   www.jointcommission.org/PatientSafety/

   The Patient Safety pages on the Joint Commission Web site offer information on patient safety-related standards, the National Patient Safety Goals, the Speak Up™ initiatives (a national program urging patients to become active participants on their health care team), and other resources.

15. Minnesota Alliance for Patient Safety
   www.mnpatientsafety.org

   The Minnesota Alliance for Patient Safety is 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 working together to improve patient safety.

16. National Center for Patient Safety
   www.patientsafety.gov

   The National Center for Patient Safety (NCPS) was established in 1999 to develop and nurture a culture of safety throughout the Department of Veterans Affairs. The primary intended audience for the public Web site is health care professionals and health care administrators.

17. National Committee for Quality Assurance
   www.ncqa.org/

   The National Committee for Quality Assurance (NCQA) is a private, not-for-profit organization dedicated to improving health care quality. NCQA develops quality standards and performance measures for a broad range of health care entities. These measures and standards are the tools that organizations and individuals can use to identify opportunities for improvement. The annual reporting of performance against such measures has become a focal point for the media, consumers, and health plans, which use these results to set their improvement agendas for the following year.

18. National Patient Safety Foundation®
   www.npsf.org/

   The National Patient Safety Foundation® (NPSF) has been pursuing one mission since its founding in 1997 — to improve the safety of the health care system for the patients and families it serves. NPSF is dedicated to uniting disciplines and organizations across the continuum of care, championing a collaborative, inclusive, multistakeholder approach.

19. National Quality Forum
    www.qualityforum.org/Topics/Safety.aspx

The National Quality Forum is a nonprofit organization that aims to improve the quality of health care for all Americans through fulfillment of its three-part mission:

- Setting national priorities and goals for performance improvement;
- Endorsing national consensus standards for measuring and publicly reporting on performance; and
- Promoting the attainment of national goals through education and outreach programs.

20. Partnering With Patients To Create Safe Care
    www.ihi.org/ihi/files/Forum/2008/Handouts/DE24_PartnerPatients_Weingart.pdf (PDF, 5.4 MB) [PDF Help]; audio available in MP3 format at
    http://webmedia.unmc.edu/nursing/grants/jcuddiga/ihi2008/media/sIH08136.htm

Partnering With Patients To Create Safe Care is a presentation from the IHI National Forum by representatives at the Dana-Farber Cancer Institute. The presentation highlights Dana-Farber's journey in family-centered care and the steps needed to advance patient and family participation in safety and quality initiatives.

21. Pennsylvania Patient Safety Authority
    www.patientsafetyauthority.org/Pages/Default.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. The Web site features issues of current patient safety articles and highlights patient safety initiatives and tools. Users can browse by care setting, event (e.g., falls, medication errors), discipline, audience, and patient safety focus.

22. Pittsburgh Regional Health Initiative
    http://prhi.org/

Pittsburgh Regional Health Initiative provides a series of forums titled "Excellence in Chronic Care." Past topics include "Excellence in Chronic Care: Successes in Improving Diabetes Care," "Electronic Medical Records and Chronic Disease," "Helping Patients Achieve Diabetes Care Goals," and "Measurable Quality Improvement in Diabetes Care for Your Practice."

23. Premier Safety Institute®
    www.premierinc.com/quality-safety/tools-services/safety/index.jsp

The Premier Safety Institute provides safety resources and tools to promote a safe health care delivery environment for patients, workers, and their communities.

24. Reducing Errors in Health Care: Translating Research Into Practice

www.innovations.ahrq.gov/content.aspx?id=784

This fact sheet is featured on AHRQ's Health Care Innovations Exchange Web site. It provides research-based information on medical errors and how to reduce them. It addresses patients at risk, describes how errors occur, and suggests ways to improve patient safety and promote safety.

25. TransforMED Medical Home Tools and Resources

http://transformed.com/resources.cfm

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

26. World Health Organization Collaborating Centre for Patient Safety Solutions

www.ccforpatientsafety.org/patient-safety-solutions

The Joint Commission, Joint Commission International, and World Health Organization host the Centre for Patient Safety Solutions. This Web site provides information about nine solutions for improving patient safety approved by the International Steering Committee. Areas covered by the solutions include: (1) Look-Alike, Sound-Alike Medication Names, (2) Patient Identification, (3) Communication During Patient Hand-Overs, (4) Performance of Correct Procedure at Correct Body Site, (5) Control of Concentrated Electrolyte Solutions, (6) Assuring Medication Accuracy at Transitions in Care, (7) Avoiding Catheter and Tubing Misconnections, (8) Single Use of Injection Devices, and (9) Improved Hand Hygiene To Prevent Health Care-Associated Infection.

27. Why Not the Best?

http://whynotthebest.org/contents/

Why Not the Best is a health care quality improvement resource from the Commonwealth Fund. In this resource, health care organizations share successful strategies and tools to create safe, reliable health care processes and deliver high-quality care to patients. Case studies and tools are linked to performance measures for particular conditions or areas of care.

Resources by Dimension

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

Dimension 1. Teamwork

1. **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 AHRQ Patient Safety Network explains this topic further and provides links for more information on what is new in teamwork training.

2. **Patient Safety Through Teamwork and Communication Toolkit**
   www.innovations.ahrq.gov/content.aspx?id=1947

   This toolkit is featured on AHRQ's Health Care Innovations Exchange Web site. It consists of an education guide and communication tools. The education guide provides a plan for the education and integration of communication and teamwork factors into clinical practice. The communication tools section provides a description for each of the following tools along with provisions for implementation:

   - Multidisciplinary Rounding
   - Huddles
   - Rapid Response and Escalation
   - Structured Communication

3. **TeamSTEPPS® — Team Strategies and Tools to Enhance Performance and Patient Safety**
   http://teamstepps.ahrq.gov/

   Developed jointly by the Department of Defense (DoD) and AHRQ, 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. Following extensive field testing in the Military Health System (MHS) and several civilian organizations, a multimedia TeamSTEPPS toolkit is now available in the public domain to civilian health care facilities and medical practices. Additional TeamSTEPPS tools are in development.

4. **"TeamSTEPPS®: Integrating Teamwork Principles Into Healthcare Practice": An article in the November/December 2006 issue of Patient Safety and Quality Healthcare**
   www.psqh.com/novdec06/ahrq.html

5. **TeamSTEPPS® Readiness Assessment Tool**
   http://teamstepps.ahrq.gov/ahrqchecklist.aspx

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

6. **TeamSTEPPS® Rapid Response Systems (RRS) Training Module**
   http://teamstepps.ahrq.gov/abouttoolsmaterials.htm (order information available on this Web site)

   This evidence-based module will provide insight into the core concepts of teamwork as they are applied to the rapid response system (RRS). The module contains an instructor guide in electronic form and training slides that include a high-quality video vignette of teamwork as it relates to RRS. This product comes as a CD-ROM with printable files (Word®, PDF, and PowerPoint®).

Dimension 2. Patient Care Tracking/Followup

1. **Group Primary Care Visits Improve Outcomes for Patients With Chronic Conditions**
   www.innovations.ahrq.gov/content.aspx?id=1890

   This featured profile is available on AHRQ'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 precolonoscopy. 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. **Monthly Text Messages Increase Compliance With Recommended Blood Glucose Testing in Medicaid Managed Care Enrollees With Diabetes**
   www.innovations.ahrq.gov/content.aspx?id=2395

   This featured profile is available on AHRQ'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.

3. **Nurse-Led Telephone Outreach More Than Doubles Pneumococcal Vaccination Rates for At-Risk Individuals**
   www.innovations.ahrq.gov/content.aspx?id=1721

   This featured profile is available on AHRQ'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.

4. **Palliative Care Nurses in Primary Care Clinics Reduce Hospital Admissions, Increase Use of Hospice and Home Care for Patients Nearing End of Life**
   www.innovations.ahrq.gov/content.aspx?id=1738

   This featured profile is available on AHRQ'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.

5. **Primary Care Practices Improve Patient Satisfaction With Communication of Outpatient Laboratory Test Results**
   www.innovations.ahrq.gov/content.aspx?id=1741

   This featured profile is available on AHRQ'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.

6. **Real-Time Clinical Reminder System Improves Performance on Quality Measures**
   www.innovations.ahrq.gov/content.aspx?id=1771

   This featured profile is available on AHRQ'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.

Dimension 3. Organizational Learning

1. **AHRQ Health Care Innovations Exchange Learn & Network**
   www.innovations.ahrq.gov/learn_network/listall.aspx

   This part of the Health Care Innovations Exchange Web site has information on how to introduce innovations to and organization and how to encourage others to think "outside the box" and accept new ideas. Learn & Network has advice and ideas from experts and

practitioners and insights from the literature. Users can also participate in discussions and learning networks on specific topics.

2. **Change the Work Environment**
   www.ihi.org/IHI/Topics/Improvement/ImprovementMethods/Changes/Change+the+Work+Environment.htm

   Changes to the environments in which people work, study, and live can often provide leverage for improvements in performance. This IHI Web page provides information about how to change the work environment.

3. **Decision Tree for Unsafe Acts Culpability**
   www.ihi.org/IHI/Topics/PatientSafety/SafetyGeneral/Tools/Decision+Tree+for+Unsafe+Acts+Culpability.htm

   The decision tree for unsafe acts culpability is a tool available for download from IHI's 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.

4. **Error Proofing**
   www.ihi.org/IHI/Topics/Improvement/ImprovementMethods/Changes/Error+Proofing.htm

   Errors occur when actions do not agree with intentions even though people are capable of carrying out the task. This IHI Web page outlines error proofing. It includes links to the following topics that contain more specific information and strategies:

   - Use Affordances
   - Use Constraints
   - Use Differentiation
   - Use Reminders

5. **Improvement Tracker Tools**
   www.ihi.org/ihi/workspace/tracker/

   The Improvement Tracker available through the IHI Web site allows users to track any of the measures currently available in the Topics area of IHI.org. Users can select the measure they want to track (or create a custom measure), set their aim, and enter their data. A section called "Office Practices: Primary Care Access" provides links to tracking tools for medical offices.

6. **Institute for Healthcare Improvement: Plan-Do-Study-Act (PDSA) Worksheet (IHI Tool)**
www.ihi.org/IHI/Topics/Improvement/ImprovementMethods/Tools/Plan-Do-Study-Act+(PDSA)+Worksheet.htm

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

7. **Integrating Chronic Care and Business Strategies in the Safety Net: A Toolkit for Primary Care Practices and Clinics**
www.innovations.ahrq.gov/content.aspx?id=2371

This toolkit is featured on AHRQ's Health Care Innovations Exchange Web site. It is for safety net providers interested in implementing the Chronic Care Model effectively and sustainably at their organizations while attending to their financial realities. The toolkit provides a step-by-step practical approach to guide primary care teams through four phases of quality improvement.

8. **Mistake Proofing the Design of Health Care Processes**
www.innovations.ahrq.gov/content.aspx?id=482

This resource is featured on AHRQ's Health Care Innovations Exchange Web site. The resource is a synthesis of practical examples from the real world of health care on the use of process or design features to prevent medical errors or the negative impact of errors. It contains more than 150 examples of mistake proofing that can be applied in health care, in many cases relatively inexpensively. By using this resource, risk managers and chief medical officers can benefit from commonsense approaches to reducing risk and litigation. In addition, organizations can find the groundwork for a successful program that fosters innovation and creativity as they address their patient safety concerns and approaches.

9. **National Center for Patient Safety Root Cause Analysis Tools**
www.va.gov/ncps/CogAids/RCA/index.html

Since 1999, NCPS has developed tools, training, and software to facilitate patient safety and root cause analysis (RCA) investigations. This guide functions as a cognitive aid to help teams in developing a chronological event flow diagram (an understanding of what occurred) and a cause-and-effect diagram (why the event occurred).

10. **Patient Safety Tools for Physician Practices**
www.mgma.com/solutions/landing.aspx?cid=24572&id1=25820&id3=25764&hid=25288&mid=25820

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.

11. **Practice Enhancement Assistants Improve Quality of Care in Primary Care Practices**
www.innovations.ahrq.gov/content.aspx?id=1768

This featured profile is available on AHRQ's Health Care Innovations Exchange Web site. Practice enhancement assistants work across primary care practices to improve patient care through practice audits and feedback, staff training, sharing of innovative ideas among practices, support for development of systems and infrastructure, and development and coordination of quality improvement initiatives. Practice enhancement assistants also help practices participate in research that improves primary care delivery. The program has helped practices establish structures, processes, and infrastructure (e.g., patient tracking capabilities) that have led to improvements in areas such as diabetes care and delivery of preventive services.

12. **Patient Safety Primer: Root Cause Analysis**
www.psnet.ahrq.gov/primer.aspx?primerID=10

Root cause analysis (RCA) is a structured method used to analyze adverse events. Initially developed to analyze industrial accidents, RCA is now widely deployed as an error analysis tool in health care. The AHRQ Patient Safety Network explains this topic further and provides links for more information on what is new in RCA.

13. **Will It Work Here?: A Decisionmaker's Guide to Adopting Innovations**
www.innovations.ahrq.gov/resources/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.

Dimension 4. Overall Perceptions of Patient Safety

1. **Ambulatory Patient Safety Toolkit**
www.premierinc.com/safety/safety-share/12-03-downloads/08_scope_toolkit.pdf (PDF, 6 MB) [PDF Help]

This toolkit from Gundersen Lutheran Health System's Safety Collaborative for the Outpatient Environment (SCOPE) provides resources and project summaries to help medical providers evaluate patient safety through structural and process measures. Topics include an accurate and complete medication list; standardized prescription writing; warning labels for look alike, sound alike drugs; and nonpunitive error reporting.

2. **Basic Patient Safety Program Resource Guide for "Getting Started"**
   www.innovations.ahrq.gov/content.aspx?id=383

   This resource guide is featured on AHRQ's Health Care Innovations Exchange Web site. It has tools to help health care facilities implement a patient safety program. This toolkit includes the following program tools, all of which may be customized as needed:

   - Generic safety plan: template
   - Comprehensive medical safety program
   - Quality and safety officer job description: template
   - Organized assignments for accompanying patient safety plan or program
   - American Society for Healthcare Risk Management: perspective on disclosure of information on unanticipated outcomes
   - Checklist for patient safety and Joint Commission on the Accreditation of Healthcare Organizations standards

3. **Improving Patient Safety in Hospitals: Turning Ideas Into Action**
   www.med.umich.edu/patientsafetytoolkit/index.htm

   Although this toolkit was designed for hospitals, some sections of this toolkit may apply to medical offices. The University of Michigan Health System developed a resource for clinicians and administrative leaders responsible for strategic initiatives aimed at creating and sustaining quality of care and patient safety in hospitals. This patient safety toolkit presents ways of turning patient safety ideals into practical and achievable strategies. It includes information on the following topics: overview, safety plan, adverse events, infection prevention and control, safety culture, safety curriculum, medication safety, and disclosure.

4. **Making Health Care Safer: A Critical Analysis of Patient Safety Practices**
   www.innovations.ahrq.gov/content.aspx?id=399

   This evidence report is featured on AHRQ's Health Care Innovations Exchange Web site. It presents practices relevant to improving patient safety, focusing on hospital care, nursing homes, ambulatory care, and patient self-management. It defines patient safety practices, provides a critical appraisal of the evidence, rates the practices, and identifies opportunities for future research.

5. **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 AHRQ Patient Safety Network explains this topic further and provides links for more information on what is new in safety culture.

6. **Studer Group Toolkit: Patient Safety**
   www.innovations.ahrq.gov/content.aspx?id=2592

   This toolkit is featured on AHRQ's Health Care Innovations Exchange Web site. It provides health care leaders and frontline staff specific tactics they can immediately put into action to improve patient safety outcomes. By routinizing specific behaviors, organizations can improve patient safety without purchasing new equipment, adding staff, or spending additional time to put them into practice. The actions are divided into eight sections, each of which has been identified as a priority area for health care organizations to address as they seek to provide safer care.

Dimension 5. Staff Training

1. **Point-of-Care Complexity Assessment Helps Primary Care Clinicians Identify Barriers to Improved Health and Craft Integrated Care Plans**
   www.innovations.ahrq.gov/content.aspx?id=2496

   This featured profile is available on AHRQ'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.

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

1. **Appoint a Safety Champion for Every Unit**
   www.ihi.org/IHI/Topics/PatientSafety/SafetyGeneral/Changes/IndividualChanges/Appoint+a+Safety+Champion+for+Every+Unit.htm

   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.

2. **Conduct Patient Safety Leadership WalkRounds™**
   www.ihi.org/IHI/Topics/PatientSafety/SafetyGeneral/Changes/IndividualChanges/Conduct+Patient+Safety+Leadership+WalkRounds.htm

   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 IHI Web page discusses the benefits for management making regular rounds and provides links to downloadable tools. One specific tool created by Dr. Allan Frankel is highlighted: www.wsha.org/files/82/WalkRounds1.pdf (PDF, 78.4 KB) [PDF Help].

3. **Framework for Leadership Improvement**
www.ihi.org/IHI/Topics/LeadingSystemImprovement/Leadership/EmergingContent/AFrameworkforLeadershipofImprovement.htm

This framework, developed by IHI, was built on the concepts of "will, ideas, and execution." It organizes leadership processes that focus the organization and senior leaders on improvement.

4. **Leadership Guide to Patient Safety**
www.patientsafetyboard.org/DesktopModules/Documents/DocumentsView.aspx?tabID=0&ItemID=31896&MId=5204&wversion=Staging (PDF, 416 KB) [PDF Help]

This Leadership Guide to Patient Safety is part of IHI's Innovation series. It shares the experience of senior leaders who have decided to address patient safety and quality as a strategic imperative within their organizations. It presents what can be done to make the dramatic changes that are needed to ensure that patients are not harmed by the care systems they trust to heal them.

5. **Making Strides in Safety**
www.innovations.ahrq.gov/content.aspx?id=2023

The Making Strides in Safety Program is featured on AHRQ's Health Care Innovations Exchange Web site. It encourages physician leadership and involvement in improving patient care. The Making Strides in Safety Web site includes downloadable tools to engage and support physicians in national safety and quality initiatives and campaigns in the settings in which they provide care. They include toolkits on participation, implementation, and health delivery systems improvement as well as a tip sheet on communication effectiveness.

6. **Patient Safety Rounding Toolkit**
www.dana-farber.org/pat/patient-safety/patient-safety-resources/patient-rounding-toolkit.html

The Patient Safety Rounding Toolkit is available to download from the Dana-Farber Cancer Institute. It provides resources for assessing whether an organization will benefit from patient safety rounds and for designing and implementing a patient safety rounds program.

Dimension 7. Communication About Error

1. **Conduct Safety Briefings**
www.ihi.org/IHI/Topics/PatientSafety/SafetyGeneral/Changes/IndividualChanges/Conduct+Safety+Briefings.htm

Safety briefings in patient care units are tools to increase safety awareness among frontline staff and foster a culture of safety. This IHI Web page identifies tips and tools for conducting safety briefings.

2. **Patient Safety and the "Just Culture": A Primer for Health Care Executives**
   http://psnet.ahrq.gov/resource.aspx?resourceID=1582

   Accountability is a concept that many leaders wrestle with as they steer their organizations and patients toward understanding and accepting the idea of a blameless culture within the context of medical injury. This report by David Marx is available for download through the AHRQ Patient Safety Network and outlines the complex nature of deciding how best to hold individuals accountable for mistakes.

3. **Patient Safety and the "Just Culture": A Presentation by David Marx, J.D.**
   www.health.state.ny.us/professionals/patients/patient_safety/conference/2007/docs/patient_safety_and_the_just_culture.pdf (PDF, 1.4 MB) [PDF Help]

   This presentation on "Patient Safety and the Just Culture" by David Marx defines just culture, the safety task, the just culture model, and statewide initiatives in New York.

4. **Provide Feedback to Frontline Staff**
   www.ihi.org/IHI/Topics/PatientSafety/SafetyGeneral/Changes/IndividualChanges/Provide+Feedback+to+Front-Line+Staff.htm

   Feedback to frontline staff is critical in demonstrating a commitment to safety and ensuring that staff members continue to report safety issues. This IHI Web page identifies tips and tools for communicatinig feedback.

5. **Voluntary, Anonymous, Nonpunitive System Leads to a Significant Increase in Reporting of Errors in Ambulatory Pediatric Practice**
   www.innovations.ahrq.gov/content.aspx?id=1901

   This featured profile is available on AHRQ'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.

6. **Voluntary Error Reporting Program Focusing on Systems Issues Increases Reporting and Contributes to Reduction in Liability Claims at Outpatient Clinic**
   www.innovations.ahrq.gov/content.aspx?id=2049

   This featured profile is available on AHRQ'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 sixfold (from 20 to 120), while the number of liability claims has declined. While 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:

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

Dimension 8. Communication Openness

1. **Arizona Hospital and Healthcare Association SBAR Communication**
   www.azhha.org/patient_safety/sbar.aspx

   This SBAR (Situation-Background-Assessment-Recommendation) Communication toolkit, available for download through the Arizona Hospital and Healthcare Association, is designed to assist facilities through the implementation and training of SBAR communication. Items included in this tool kit are samples of SBAR documents and staff education, including practice scenarios to use SBAR and policy recommendations.

2. **E-Mail Enhances Communication With and Access to Pediatrician for Patients and Families**
   www.innovations.ahrq.gov/content.aspx?id=1693

   This featured profile is available on AHRQ'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.

3. **SBAR Technique for Communication: A Situational Briefing Model**
   www.ihi.org/IHI/Topics/PatientSafety/SafetyGeneral/Tools/SBARTechniqueforCommunicationASituationalBriefingModel.htm

   The SBAR technique provides a framework for communication between members of the health care team about a patient's condition. This tool from IHI has two documents. The first, "SBAR Report to Physician About a Critical Situation," is a worksheet/script a provider can use to prepare to communicate with a physician about a critically ill patient. The second, "Guidelines for Communicating With Physicians Using the SBAR Process," details how to carry out the SBAR technique.

Cross-references to resources already described:

Dimension 1. Teamwork, [Patient Safety Through Teamwork and Communication Toolkit](#).

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

Dimension 9. Patient Safety and Quality Issues

Access to Care

1. **Balance Supply and Demand on a Daily, Weekly, and Long-Term Basis**
    www.ihi.org/IHI/Topics/OfficePractices/Access/Changes/BalanceSupplyandDemandonaDailyWeeklyandLongTermBasis.htm

    The foundation of improved access scheduling is matching supply and demand on a daily, weekly, and monthly basis. This 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**
    www.ihi.org/IHI/Topics/OfficePractices/Access/Changes/DecreaseDemandforAppointments.htm

    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 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**
    www.ihi.org/IHI/Topics/OfficePractices/Access/Changes/MeasureandUnderstandSupplyandDemand.htm

    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, including tools and resources such as the practice supply worksheet and the true demand formula.

4. **Optimize the Care Team**
    www.ihi.org/IHI/Topics/OfficePractices/Access/Changes/OptimizetheCareTeam.htm

    Optimizing the care team is critical to maximizing the supply of the clinic and improving the daily flow of work. This IHI Web page contains information on decreasing demand for appointments, including links to tools such as the practice supply worksheet.

5. **Open Scheduling and Related Strategies Lead to Zero Wait Time for Appointments and Few No Shows at Family Practice**
    www.innovations.ahrq.gov/content.aspx?id=1907

    This featured profile is available on AHRQ'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 5 percent.

6. **Reduce Scheduling Complexity**
   www.ihi.org/IHI/Topics/OfficePractices/Access/Changes/ReduceSchedulingComplexity.htm

   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.

7. **Revamped Scheduling Systems Promote Access, Reduce No Shows, and Enhance Quality, Patient Satisfaction, and Revenues in Primary Care Practice**
   www.innovations.ahrq.gov/content.aspx?id=1856

   This featured profile is available on AHRQ's Health Care Innovations Exchange Web site. Using the "advanced access model," a primary care practice revamped its appointment scheduling, tracking, and reminder processes, with the goal of enhancing access to same-day appointments. A pre- and postimplementation comparison shows that the program enhanced access to same-day appointments, reduced no shows, and increased the provision of evidence-based care, patient satisfaction, patient volume, and revenues.

8. **Six Sigma-Inspired Workflow Redesign Enhances Access to Care and Increases Patient Satisfaction, Visits, and Revenues in Obstetrics and Gynecology Residency Clinic**
   www.innovations.ahrq.gov/content.aspx?id=1868

   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. **Patient Identification**
   www.camlt.org/DL_web/963_pat_id.pdf (PDF, 110 KB) [PDF Help]

   This course packet prepared for the California Association for Medical Laboratory Technology outlines the importance of patient identification and explains how this task can be completed in inpatient and outpatient settings.

Cross-reference to resource already described:

General Resources, 2010 Ambulatory Care National Patient Safety 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**
www.innovations.ahrq.gov/content.aspx?id=274

   This featured profile is available on AHRQ'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. **TransforMED Health Information Technology Resources**
http://transformed.com/resources/HIT.cfm

   TransforMED 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:

Dimension 2. Patient Care Tracking/Followup, Real-Time Clinical Reminder System Improves Performance on Quality Measures.

Medical Equipment

No resources have been identified at this time.

Medication

1. **Automated Pharmacy Alerts Followed by Pharmacist-Physician Collaboration Reduce Inappropriate Prescriptions Among Elderly Outpatients**
www.innovations.ahrq.gov/content.aspx?id=1780

   This featured profile is available on AHRQ's Health Care Innovations Exchange Web site. Kaiser Permanente Colorado developed a computerized alert system to notify pharmacists when elderly patients are prescribed potentially inappropriate medications. Alerted pharmacists consult with the physicians to discuss the prescription. A 1-year prospective randomized controlled trial found that the program reduced inappropriate prescriptions, with 1.8 percent of intervention patients receiving them, compared to 2.2 percent of control group patients.

2. **Aurora Health Care Medication List Toolkit**
www.patientsafety.org/page/109587/

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

3. **Look-Alike, Sound-Alike Medication Names**
   www.ccforpatientsafety.org/common/pdfs/fpdf/Presskit/PS-Solution1.pdf (PDF, 658 KB)
   [PDF Help]

   Confusing drug names is one of the most common causes of medication errors and is a worldwide concern. With tens of thousands of drugs currently on the market, the potential for error created by confusing brand or generic drug names and packaging is significant. This resource from the World Health Organization Collaborating Centre for Patient Safety Solutions provides information about look-alike, sound-alike medication names as well as strategies for improvement.

4. **Medication Reconciliation Toolkit**
   www.innovations.ahrq.gov/content.aspx?id=2173

   This medication reconciliation toolkit is featured on AHRQ's Health Care Innovations Exchange Web site. From the Department of Defense Patient Safety Program, this tool can help health care providers ensure that their patients receive safe medical care. Medication reconciliation is a systematic process designed to improve communication during transitions of care. It begins with the acquisition and generation of a current, accurate, and single-source medication profile for use by all health care providers dealing with a specific patient at the time any form of care is delivered. This process promotes seamless communication among a patient's care providers to prevent inadvertent duplications or omissions.

5. **Medications At Transitions and Clinical Handoffs (MATCH) Initiative**
   www.innovations.ahrq.gov/content.aspx?id=1979

   This toolkit is featured on AHRQ's Health Care Innovations Exchange Web site. The goal of the Medications At Transitions and Clinical Handoffs (MATCH) Initiative is to measurably decrease the number of discrepant medication orders and the associated potential and actual patient harm. This toolkit is designed to assist all types of organizations, whether caring for inpatients or outpatients or using an electronic medical record, a paper-based system, or both.

6. **Patient Education and Staff Training Significantly Improves Medication Reconciliation in Outpatient Clinics**
   www.innovations.ahrq.gov/content.aspx?id=1762

   This featured profile is available on AHRQ's Health Care Innovations Exchange Web site. Mayo Clinic researchers developed a medication reconciliation intervention program for outpatient primary care settings. The program improved the accuracy of medication lists in the practice's electronic medical records relative to patient reports of actual prescription and nonprescription drugs and supplements used. The intervention included communicating with patients so that they were better prepared to provide information about their medications at the time of the visit. It also included provider education on the importance of medication reconciliation and methods to improve documentation through patient and provider collaboration.

7. **Patient Safety Primer: Medication Reconciliation**
   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 AHRQ Patient Safety Network explains this topic further and provides links for more information on what is new in medication reconciliation.

8. **Reconciliation of Patient and Provider Medication Lists Reduces Discrepancies and Enhances Medication Safety in Physician Clinics**
   www.innovations.ahrq.gov/content.aspx?id=2048

   This featured profile is available on AHRQ's Health Care Innovations Exchange Web site. PeaceHealth, a nonprofit integrated system, established a process to allow patients and providers in physician offices to reconcile two medication lists: one maintained by patients either manually or on a Web-based personal health record and one maintained by providers on an electronic medical record. The new medication reconciliation process significantly reduced the number of discrepancies between the lists, leading to enhanced safety and high levels of patient and provider satisfaction.

Diagnostics and Tests

Cross-reference to resource already described:

Dimension 2. Patient Care Tracking/Followup, Primary Care Practices Improve Patient Satisfaction With Communication of Outpatient Laboratory Test Results.

Dimension 10. Office Processes and Standardization

1. **Create Contingency Plans**
   www.ihi.org/IHI/Topics/OfficePractices/Access/Changes/CreateContingencyPlans.htm

   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 IHI Web page provides information about how to create contingency plans.

2. **Focus on Variation**
   www.ihi.org/IHI/Topics/Improvement/ImprovementMethods/Changes/Focus+on+Variation.htm

   Reduction of variation will improve the predictability of outcomes (may actually exceed customer expectations) and help to reduce the frequency of poor results. This IHI Web page contains information on how to reduce variation, including resources for standardization and developing contingency plans.

3. **Information Technology (IT) Staff-Clinician Team Addresses IT Problems Affecting Providers and Patient Care, Leading to Increased System Usage and Efficiency**
www.innovations.ahrq.gov/content.aspx?id=1748

   This featured profile is available on AHRQ'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.

4. **Patient Encounter Form**
www.innovations.ahrq.gov/content.aspx?id=2521

   This form is featured on AHRQ's Health Care Innovations Exchange Web site. It can be used as a model for clinicians to establish a reminder system to improve quality measures and goals. Patient visits can be guided by this customizable patient encounter form that is designed to incorporate a practice's quality goals and measures. It can be printed automatically at patient arrival, printed manually on demand, or completed using a real-time Web interface.

5. **Real-Time Decision and Documentation Support Increases Adherence to Recommended Care for Respiratory Infections, Diabetes, and Heart Disease**
www.innovations.ahrq.gov/content.aspx?id=2431

   This featured profile is available on AHRQ's Health Care Innovations Exchange Web site. Partners HealthCare System seeks to ensure appropriate care for patients with acute respiratory infections, coronary artery disease, and diabetes by providing real-time clinical decision and documentation support through the system's electronic medical record. Pre- and postimplementation pilot studies show that the system has improved the appropriateness of antibiotic prescribing for acute respiratory infections and increased use of appropriate therapies and improved documentation for patients with coronary artery disease and diabetes. Results from a randomized controlled trial of the system have not yet been published.

Cross-references to resources already described:

Dimension 2. Patient Care Tracking/Followup, Primary Care Practices Improve Patient Satisfaction With Communication of Outpatient Laboratory Test Results.

Dimension 9. Patient Safety and Quality Issues, Charts and Medical Records, Electronic Medical Record-Facilitated Workflow Changes Enhance Quality and Efficiency, Generating Positive Return on Investment in Small Pediatrics Practice.

Dimension 11. Information Exchange With Other Settings

1. **Onsite Nurses Work With Primary Care Physicians To Manage Care Across Settings, Resulting in Improved Patient Satisfaction and Lower Utilization and Costs for Chronically Ill Seniors**
   www.innovations.ahrq.gov/content.aspx?id=1752

   This featured profile is available on AHRQ'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.

2. **Strategies and Tools To Improve Health Care Handoffs and Transitions**
   www.unmc.edu/rural/patient-safety/tool-time/TT2-053006-DOD-SBAR-SafetyBriefings/DOD%20Handoff%20-%20I%20Pass%20the%20Baton.pdf (PDF, 99 KB) [PDF Help

   This resource from the Department of Defense provides an overview on the importance of structured handoff processes and provides information on the Joint Commission requirement. The resource illustrates a handoff communication tool that can be recalled through the mnemonic device, "I PASS the BATON."

3. **Transitions of Care Checklist**
   www.ntocc.org/Portals/0/TOC_Checklist.pdf (PDF, 201 KB) [PDF Help]

   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-references to resources already described:

Dimension 2. Patient Care Tracking/Followup, Palliative Care Nurses in Primary Care Clinics Reduce Hospital Admissions, Increase Use of Hospice and Home Care for Patients Nearing End of Life.

Dimension 9. Patient Safety and Quality Issues, Medication, Automated Pharmacy Alerts Followed by Pharmacist-Physician Collaboration Reduce Inappropriate Prescriptions Among Elderly Outpatients.

Dimension 9. Patient Safety and Quality Issues, Medication, Medications At Transitions and Clinical Handoffs (MATCH) Initiative

Dimension 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**
   www.innovations.ahrq.gov/content.aspx?id=1785

   This featured profile is available on AHRQ'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**
   www.ihi.org/IHI/Topics/OfficePractices/Access/Changes/ManagePanelSizeandScopeofthePractice.htm

   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 IHI 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**
   www.ihi.org/IHI/Topics/OfficePractices/Access/Changes/PredictandAnticipatePatientNeeds.htm

   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 IHI 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**
   www.ihi.org/IHI/Topics/OfficePractices/Access/Changes/RecalibratetheSystembyWorkingDowntheBacklog.htm

   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.

Cross-reference to resource already described:

Dimension 9. Patient Safety and Quality Issues, Access, 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. **CAHPS® Clinician and Group Survey**
    https://www.cahps.ahrq.gov/content/products/CG/PROD_CG_CG40Products.asp?p=1021&s=213

    The CAHPS® program is a public-private initiative to develop standardized surveys of patients' experiences with ambulatory and facility-level care. This Web site provides information on the CAHPS Clinician and Group Survey, as well as links to the survey and reporting kit.

2. **CAHPS® Health Information Technology Item Set**
    https://www.cahps.ahrq.gov/content/products/HIT/PROD_HIT_Intro.asp?p=1021

    The CAHPS® Team has initiated the development of a new set of supplemental items for the CAHPS Clinician and Group Survey that focuses on patients' experiences with health information technology (HIT). In a physician's office, uses of HIT include secure electronic messaging, electronic medical records, medication lists, personal health records, and appointment scheduling. This item set is expected to help organizations assess the patient centeredness of physician practices and groups that have adopted different kinds of information technologies.

3. **CAHPS® Health Literacy Item Set**
    https://www.cahps.ahrq.gov/content/products/HL/PROD_HL_Intro.asp?p=1021

    The CAHPS® Consortium has been developing a supplemental set for the CAHPS Clinician and Group Survey that focuses on assessing providers' activities to foster and improve the health literacy of patients. Health literacy is commonly defined as patients' ability to obtain, process, and understand the basic health information and services they need to make appropriate health decisions. This work on promoting health literacy is part of AHRQ's continuing efforts to encourage greater emphasis in the provider community on patient-centered care.

4. **Health Literacy Universal Precautions Toolkit**
    www.ahrq.gov/qual/literacy/

    AHRQ 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.

5. **Institute for Family-Centered Care**
   www.familycenteredcare.org/tools/downloads.html

   The Institute for 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 workplan for starting a patient and family advisory council.

6. **Patient-Centered Primary Care Collaborative**
   www.pcpcc.net/

   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.

7. **Producer/Customer Interface**
   www.ihi.org/IHI/Topics/Improvement/ImprovementMethods/Changes/Producer+Customer+Interface.htm

   To benefit from improvements in quality of products and services, the customer must recognize and appreciate the improvements. This IHI Web page provides information about the interface between producers and providers and their customers.

Effective

1. **Placing Mental Health Specialists in Primary Care Settings Enhances Patient Engagement, Produces Favorable Results Relative to Evidence-Based Care**
   www.innovations.ahrq.gov/content.aspx?id=1882

   This featured profile is available on AHRQ'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.

2. **Team-Based Ownership Over Defined Patient Panels Supported by Information Technology Enhances Provision of Evidence-Based Care**
   www.innovations.ahrq.gov/content.aspx?id=1699

   This featured profile is available on AHRQ's Health Care Innovations Exchange Web site. Total Panel Ownership, developed by Kaiser Permanente Hawaii and Kaiser Permanente Northwest, represents a population-based approach to care delivery. Self-governing teams of primary health care providers develop and execute proactive plans to address gaps in care for a defined panel of patients during office visits and through followup services and outreach. Kaiser's newly developed Web-based Panel Support Tool facilitates these efforts by highlighting discrepancies between recommended and actual care. A number of care gaps have been reduced as a result of these efforts.

Timely

1. **Manage Time**
   www.ihi.org/IHI/Topics/Improvement/ImprovementMethods/Changes/Manage+Time.htm

   This age-old concept provides an opportunity to make time a focal point for improving any organization. This IHI Web page provides information and links to strategies for managing time.

Cross-reference to resources already described:

Dimension 9. Patient Safety and Quality Issues, Access to Care.

Efficient

1. **Eliminate Waste**
   www.ihi.org/IHI/Topics/Improvement/ImprovementMethods/Changes/Eliminate+Waste.htm

   In a broad sense, waste can be considered as any activity or resource in an organization that does not add value to an external customer. This IHI Web page provides information about eliminating waste.

2. **Going Lean in Health Care**
   www.ihi.org/IHI/Results/WhitePapers/GoingLeaninHealthCare.htm

   This is a white paper on the IHI Web site that defines going lean in health care. In addition, it provides examples of lean thinking applied to health care that, when applied rigorously and throughout an entire organization, demonstrate a positive impact on productivity, cost, quality, and timely delivery of services.

3. **Improve Workflow and Remove Waste**
   www.ihi.org/IHI/Topics/OfficePractices/Access/Changes/ImproveWorkFlowandRemoveWaste.htm

   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 work flow.

4. **Optimize Inventory**
   www.ihi.org/IHI/Topics/Improvement/ImprovementMethods/Changes/Optimize+Inventory.htm

   Inventory of all types is a possible source of waste in organizations. This IHI Web page provides information about how to optimize inventory.

5. **Patient Cycle Tool**
   www.ihi.org/IHI/Topics/OfficePractices/Access/Tools/Patient+Cycle+Tool+IHI+Tool.htm

   The Patient Cycle Tool is available through the IHI Web site and allows health care providers to record the time of each step in a patient visit, which can help staff note where delays occur.

6. **Time and Motion Studies To Measure the Impact of Health IT on Clinical Workflow**
   http://healthit.ahrq.gov/portal/server.pt?open=514&objID=5554&mode=2&holderDisplayU RL=http://wci-pubcontent/publish/communities/k_o/knowledge_library/features_archive/features/using_tim e_and_motion_studies_to_measure_the_impact_of_health_it_on_clinical_workflow.html

   Partners Healthcare developed a set of resources to help medical offices collect and study time and motion data on activities involving health information technology applications, such as electronic prescribing and computerized provider order entry. These data are then used to evaluate when and where health information technologies may be helpful in increasing efficiency.

Equitable

1. **2009 National Healthcare Disparities Report**
   www.ahrq.gov/qual/qrdr09.htm

   Examining health care disparities is an integral part of improving health care quality. Health care disparities are the differences or gaps in care experienced by one population compared with another population. This 2009 report is the seventh National Healthcare Disparities Report produced by AHRQ.

2. **Bilingual, Culturally Competent Managers Enhance Access to Prenatal Care for Migrant Women, Leading to Potential for Improved Birth Outcomes**
   www.innovations.ahrq.gov/content.aspx?id=1685

   This featured profile is available on AHRQ'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**
   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**
www.innovations.ahrq.gov/content.aspx?id=2243

   This featured profile is available on AHRQ'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.