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

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/professionals/quality-patient-safety/patientsafetyculture/medical-office/index.html).

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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Alphabetical Index of Resources

General Resources

1. 10 Tips to Help Promote Patient Safety
http://www.ashrm.org/ashrm/education/programs/patient_safety/files/NPSAW-tip-sheet.pdf

This fact sheet lists 10 patient safety concerns and offers tips to address them.

2. 2012 National Healthcare Quality Report
http://nhqrnet.ahrq.gov/inhqrdr/reports/nhqr

This report is featured on the Agency for Healthcare Research and Quality's Web site. The key function of the National Healthcare Quality Report is to summarize the state of health care quality and access for the Nation, and report on progress and opportunities for improving health care quality. This report measures trends in effectiveness of care, patient safety, timeliness of care, patient centeredness, and efficiency of care. The 2012 report presents expanded analyses of care received by older Americans. It also addresses six priority areas for quality improvement, as identified in the *National Strategy for Quality Improvement in Health Care*, and presents novel strategies for improving quality and reducing disparities from AHRQ's Health Care Innovations Exchange.

3. 2014 National Patient Safety Goals: Ambulatory Care
http://www.jointcommission.org/standards_information/npsgs.aspx

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.

4. 30 Safe Practices for Better Health Care Fact Sheet
http://www.ahrq.gov/research/findings/factsheets/errors-safety/30safe/index.html

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.

5. AAAHC Institute Research and Toolkits
http://www.aaahc.org/en/institute/Resources/

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 decisionmaking and patient management.

6. AHRQ Health Care Innovations Exchange
http://www.innovations.ahrq.gov/

The Agency for Healthcare Research and Quality'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 AHRQ's mission to improve the safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity of care, with a particular emphasis on reducing disparities in health care and health among racial, ethnic, and socioeconomic groups.

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

7. AHRQ Medical Errors and Patient Safety
http://www.ahrq.gov/research/findings/factsheets/errors-safety/

The Agency for Healthcare Research and Quality's Medical Errors and Patient Safety Web site provides links to various fact sheets including information on how to improve health care quality, reduce and prevent adverse drug events, patient safety research highlights, and other related topics.

8. AHRQ Patient Safety Network
http://www.psnet.ahrq.gov/

The 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, AHRQ PSNet provides powerful searching and browsing capability, as well as the ability for diverse users to customize the site around their interests (My PSNet). It also is tightly coupled with AHRQ WebM&M, the popular monthly journal that features user-submitted cases of medical errors, expert commentaries, and perspectives on patient safety.

9. AHRQ Quality and Patient Safety
http://www.ahrq.gov/qual/errorsix.htm

The Agency for Healthcare Research and Quality's Quality and Patient Safety Web page provides links to various resources and tools for promoting patient safety in various categories, including:

- Comprehensive Unit-based Safety Program (CUSP)
- Patient Safety Measure Tools & Resources
- Pharmacy Health Literacy Center
- Surveys on Patient Safety Culture
- Quality Measure Tools & Resources

10. Always Events® Toolbox
http://alwaysevents.pickerinstitute.org/?page_id=882

This tool was developed by the Picker Institute. It contains 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®.

11. 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.

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

13. Chasing Zero: Winning the War on Health Care Harm
http://www.safetyleaders.org/pages/chasingZeroDocumentary.jsp

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.

14. The Commonwealth Fund
http://www.commonwealthfund.org/

The Commonwealth Fund is a private foundation that promotes 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.

15. Consumers Advancing Patient Safety
http://www.consumersadvancingpatientsafety.org/caps/

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.

16. ConsumerMedSafety.org
http://www.consumermedsafety.org/
ConsumerMedSafety.org is designed to help consumers avoid mistakes when taking medicines. Most of the material on the Web site is written by staff from the Institute for Safe Medication Practices and includes medication safety articles, tools and resources, latest Food and Drug Administration medication alerts, and a form to report a medication error.

17. Department of Defense Patient Safety Program
http://www.health.mil/dodpatientsafety.aspx

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.

18. Department of Veterans Affairs National Center for Patient Safety
http://www.patientsafety.va.gov

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

19. Department of Veterans Affairs National Center for Patient Safety Falls Toolkit
http://www.patientsafety.va.gov/professionals/onthejob/falls.asp

The Department of Veterans Affairs National Center for Patient Safety (NCPS) worked with the Patient Safety Center of Inquiry in Tampa, Florida, and others to develop the NCPS Falls Toolkit. The toolkit is designed to aid facilities in developing a comprehensive falls prevention program. This Web site contains links to the falls notebook, media tools, and additional resources.

20. 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.

21. Guide for Developing a Community-Based Patient Safety Advisory Council
http://www.ahrq.gov/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.

22. 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, evidence-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.

23. IHI Improvement Capability Self-Assessment Tool
http://www.ihi.org/resources/Pages/Tools/IHIImprovementCapabilitySelfAssessmentTool.aspx

The Improvement Capability Self-Assessment Tool from the Institute for Healthcare Improvement is designed to assist organizations in assessing their capability in six key areas that support improvement:

- Leadership for Improvement
- Results
- Resources
- Workforce and Human Resources
- Data Infrastructure and Management
- Improvement Knowledge and Competence

24. Innovations in Planned Care
http://www.ihi.org/resources/Pages/IHIWhitePapers/InnovationsinPlannedCareWhitePaper.aspx

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

25. Institute for Healthcare Improvement
http://www.ihi.org/Pages/default.aspx

The Institute for Healthcare Improvement (IHI) is a reliable source of energy, knowledge, and support for a never-ending campaign to improve health care worldwide. The institute helps accelerate change in health care by cultivating promising concepts for improving patient care and turning those ideas into action.

26. Institute for Safe Medication Practices
http://www.ismp.org

The Institute for Safe Medication Practices (ISMP) offers a wide variety of free educational materials and services on their Web site, which include:

- 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

27. The Joint Commission: Patient Safety
http://www.jointcommission.org/topics/patient_safety.aspx

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.

28. Medically Induced Trauma Support Services (MITSS)
http://www.mitss.org/index.html

Medically Induced Trauma Support Services (MITSS) is 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. MITSS achieves its mission by:

- Creating Awareness and Education
- Direct Support Services to Patients, Families, and Clinicians
- Advocacy for Action

Tools developed to support the MITSS mission are available at: http://www.mitsstools.org/.

29. Minnesota Alliance for Patient Safety
http://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.

30. National Committee for Quality Assurance
http://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.

31. National Patient Safety Foundation®
http://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 unwavering in its determined and committed focus on uniting disciplines and organizations across the continuum of care, championing a collaborative, inclusive, multi-stakeholder approach.

32. National Quality Forum: Patient Safety
http://www.qualityforum.org/Topics/Patient_Safety.aspx

The National Quality Forum (NQF) 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.

33. Partnering to Heal: Teaming Up Against Healthcare-Associated Infections
http://www.health.gov/hai/training.asp

This training program from the U.S. Department of Health and Human Services highlights effective communication about infection control practices and ideas for creating a culture of safety to prevent healthcare-associated infections.

34. Partnering With Patients to Create Safe Care: Pushing the Boundaries
http://webmedia.unmc.edu/nursing/grants/jcuddiga/ihi2008/media/sIH08136.htm

Partnering with Patients to Create Safe Care: Pushing the Boundaries is a presentation from the Institute for Healthcare Improvement 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.

35. 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.

36. Pennsylvania Patient Safety Authority
http://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 current patient safety articles and highlights patient safety initiatives and tools. Users can browse by care setting, event (e.g., medication errors, adverse drug reaction), discipline, audience, and patient safety focus.

37. 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."

38. Premier Safety Institute®
https://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.

39. Quality Improvement Savings Tracker Worksheet
http://www.ihi.org/resources/Pages/Tools/QISavingsTrackerWorksheet.aspx

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.

40. 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

41. Safety Is Personal: Partnering With Patients and Families for the Safest Care
http://www.npsf.org/wp-content/uploads/2014/03/Safety_Is_Personal.pdf

This report from the National Patient Safety Foundation's Lucian Leape Institute is a call to action for health leaders, clinicians, and policymakers to take the necessary steps to ensure patient and family engagement at all levels of health care. It identifies specific action items for health leaders, clinicians, and policymakers to pursue in making patient and family engagement a core value in the provision of health care.

42. Seven Steps to Patient Safety in General Practice
http://www.nrls.npsa.nhs.uk/resources/collections/seven-steps-to-patient-safety/?entryid45=61598

This guide is from a series of National Patient Safety Agency publications that encourage improvements in distinct areas of medical practice in the United Kingdom. This installment 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.

43. TransforMED[SM] Medical Home Tools and Resources
http://transformed.com/resources.cfm

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

44. WHO Patient Safety – Implementing Change
http://www.who.int/patientsafety/implementation/en/

World Health Organization (WHO) Patient Safety works to ensure that patient safety measures and solutions can be implemented in a variety of health care settings worldwide. Their work on implementation ranges from providing guidelines for national and subnational patient safety reporting and learning systems to solutions to common patient safety issues.

45. Why Not the Best?: Case Studies
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 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.

2. Patient Safety Through Teamwork and Communication Toolkit
http://www.safecoms.org/ImplementationToolkit/tabid/567/Default.aspx

This toolkit consists of an education guide and communication tools. The education guide provides a plan for education and integration of communication and teamwork factors into clinical practice. The communication tools section describes each of the following tools and 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 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. Following extensive field testing in the MHS and several civilian organizations, a multimedia TeamSTEPPS® toolkit is now available in the public domain to civilian health care facilities and medical practices.

4. TeamSTEPPS® Enhancing Safety for Patients With Limited English Proficiency Module
http://www.ahrq.gov/professionals/education/curriculum-tools/teamstepps/lep/index.html

The TeamSTEPPS® Limited English Proficiency module adapts TeamSTEPPS concepts to address issues associated with language barriers in health care settings. This evidence-based module will provide insight into the core concepts of teamwork as they are applied to your work with patients who have difficulty communicating in English.

5. 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.

6. TeamSTEPPS® Rapid Response Systems (RRS) Training Module
http://www.ahrq.gov/professionals/education/curriculum-tools/teamstepps/rrs/

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 the Instructor Guide in electronic form plus training slides that include a high-quality video vignette of teamwork as it relates to RRS.

7. TeamSTEPPS® Readiness Assessment Tool
http://teamstepps.ahrq.gov/readiness/

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).

Dimension 2. Patient Care Tracking/Followup

1. Group Primary Care Visits Improve Outcomes for Patients With Chronic Conditions
http://www.innovations.ahrq.gov/content.aspx?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. **Monthly Text Messages Increase Compliance With Recommended Blood Glucose Testing in Medicaid Managed Care Enrollees With Diabetes**
http://www.innovations.ahrq.gov/content.aspx?id=2395

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.

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

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.

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

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.

5. 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.

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

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.

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

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.

Dimension 3. Organizational Learning

1. AHRQ Health Care Innovations Exchange: Learn & Network
http://innovations.ahrq.gov/learn_network.aspx

This part of the Health Care Innovations Exchange Web site has information on how to introduce innovations to an organization and how to encourage others to think "outside the box" and accept new ideas. Learn & Network has tools and resources on specific topics such as community care coordination and building relationships between clinical practices and the community to improve care.

2. Decision Tree for Unsafe Acts Culpability
http://www.ihi.org/resources/Pages/Tools/DecisionTreeforUnsafeActsCulpability.aspx

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.

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

The National Center for Patient Safety uses a multidisciplinary team approach, known as Root Cause Analysis (RCA) to study 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.

4. Integrating Chronic Care and Business Strategies in the Safety Net: A Toolkit for Primary Care Practices and Clinics
http://www.ahrq.gov/professionals/systems/primary-care/businessstrategies/index.html

This toolkit 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.

5. Mistake Proofing the Design of Health Care Processes
http://www.ahrq.gov/professionals/quality-patient-safety/patient-safety-resources/resources/mistakeproof/index.html

This resource is a synthesis of practical examples from the 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 common-sense 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.

6. Patient Safety Primer: Root Cause Analysis
http://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 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 RCA.

7. Patient Safety Tools for Physician Practices
http://www.mgma.com/pppsahome/

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.

8. Plan-Do-Study-Act (PDSA) Worksheet
http://www.ihi.org/resources/Pages/Tools/PlanDoStudyActWorksheet.aspx

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).

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

This featured profile is available on the Agency for Healthcare Research and Quality'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.

10. 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 training new practice facilitators as they 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 quality of care, patient experiences with care, and patient outcomes. This handbook is based on a demonstration program that used facilitators in safety net practices to assist in training new practice facilitators. It consists of 21 training modules, each 30 to 90 minutes long, with varying requirements for presession preparation for learners.

11. 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.

12. Quality Improvement Fundamentals Toolkit
http://www.ofmq.com/Websites/ofmq/images/QI_Fundamentals_508.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.

13. Using Change Concepts for Improvement
http://www.ihi.org/resources/Pages/Changes/UsingChangeConceptsforImprovement.aspx

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.

14. 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.

Dimension 4. Overall Perceptions of Patient Safety

1. Ambulatory Patient Safety Toolkit
https://www.premierinc.com/safety/safety-share/12-03-downloads/08_scope_toolkit.pdf

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"
https://www.premierinc.com/quality-safety/tools-services/safety/topics/patient_safety/program_tools.jsp

This resource guide provides tools to assist health care facilities implement a patient safety program. It 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
- A sample grid for listing committee assignments to document and demonstrate the interdisciplinary aspects of the organization's safety program
- A document shared by the American Society of Healthcare Risk Management that may be helpful for developing a process for disclosing medical errors to patients and family
- Checklist for patient safety and Joint Commission on the Accreditation of Healthcare Organizations standards

3. Healthcare Provider Toolkit
http://www.oneandonlycampaign.org/content/healthcare-provider-toolkit

This toolkit will help individuals and organizations educate health care providers and patients about safe injection practices. Any health care provider who 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.

4. How-to Guide: Improving Hand Hygiene
http://www.ihi.org/resources/Pages/Tools/HowtoGuideImprovingHandHygiene.aspx

The purpose of this How-to Guide is to help organizations reduce healthcare-associated infections, including infections due to antibiotic-resistant organisms, by improving hand hygiene practices and use of gloves among health care workers. The guide includes:

- A description of the case for improving hand hygiene and use of gloves among health care workers.
- Recommended evidence-based interventions that will result in improvement.
- Ways to begin improving hand hygiene compliance in your organization, including establishing a team, setting aims, testing changes, and measuring results.
- Measurement support tools.

5. Making Health Care Safer II: An Updated Critical Analysis of the Evidence for Patient Safety Practices

http://www.ahrq.gov/research/findings/evidence-based-reports/ptsafetyuptp.html

This AHRQ evidence report updates the 2001 report *Making Health Care Safer: A Critical Analysis of Patient Safety Practices.* The goal of this project was to review important patient safety practices for evidence of effectiveness, implementation, and adoption. For example, it discusses the use of clinical pharmacists to prevent adverse drug events.

6. Patient Safety Primer: Patient Safety in Ambulatory Care

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

Although 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, types of errors commonly encountered in ambulatory care, and potential strategies for improving ambulatory safety.

7. 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.

8. Patient Safety Self-Assessment Tool

http://www.ihi.org/resources/Pages/Tools/PatientSafetySelfAssessmentTool.aspx

This organizational self-assessment tool was designed by Steven Meisel, PharmD, at Fairview Health Services using information from a report published by the Agency for Healthcare Research and Quality (AHRQ) in Rockville, Maryland, USA. The tool can help staff members evaluate whether known safety practices are in place in their organizations and to find areas for improvement.

9. Studer Group Toolkit: Patient Safety
http://www.sgna.org/Portals/0/Events/Annual%20Course/2013%20-%20Austin/Karen%20Cook/Toolkit.Patient%20Safety.pdf

This toolkit provides health care leaders and frontline staff with 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. AHRQ Patient Safety Education and Training Catalogue
http://psnet.ahrq.gov/pset/index.aspx

The Agency for Healthcare Research and Quality's Patient Safety Education and Training Catalog consists of more than 300 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 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
http://www.innovations.ahrq.gov/content.aspx?id=2496

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.

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

1. Appoint a Safety Champion for Every Unit
http://www.ihi.org/resources/Pages/Changes/AppointaSafetyChampionforEveryUnit.aspx

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.ihi.org/resources/Pages/Changes/ConductPatientSafetyLeadershipWalkRounds.aspx

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. One specific tool created by Dr. Allan Frankel is highlighted: http://www.wsha.org/files/82/WalkRounds1.pdf

3. IHI Framework for Leadership for Improvement
http://www.ihi.org/resources/Pages/Tools/IHIFrameworkforLeadershipforImprovement.aspx

The Framework for Leadership for Improvement, developed by the Institute for Healthcare Improvement, was built upon 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
http://www.ihi.org/resources/Pages/IHIWhitePapers/LeadershipGuidetoPatientSafetyWhitePaper.aspx

This guide is part of the Innovation series from the Institute for Healthcare Improvement. 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 will heal them.

5. Patient Safety Rounding Toolkit
http://www.dana-farber.org/Adult-Care/Treatment-and-Support/Care-Quality-and-Safety/Patient-Safety-Resources.aspx

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. 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. Conduct Safety Briefings
http://www.ihi.org/resources/Pages/Changes/ConductSafetyBriefings.aspx

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

3. 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.

4. Patient Safety and the "Just Culture": A Primer for Health Care Executives
http://www.safer.healthcare.ucla.edu/safer/archive/ahrq/FinalPrimerDoc.pdf

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 outlines the complex nature of deciding how best to hold individuals accountable for mistakes.

5. Provide Feedback to Front-Line Staff
http://www.ihi.org/resources/Pages/Changes/ProvideFeedbacktoFrontLineStaff.aspx

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.

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

http://www.innovations.ahrq.gov/content.aspx?id= 1901

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**

http://www.innovations.ahrq.gov/content.aspx?id=2049

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

http://www.innovations.ahrq.gov/content.aspx?id=1693

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.

2. SBAR Technique for Communication: A Situational Briefing Model
http://www.ihi.org/resources/Pages/Tools/SBARTechniqueforCommunicationASituationalBriefingModel.aspx

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

3. Surveys: Nurse and Physician Attitudes About Communication and Collaboration
http://www.ihi.org/resources/Pages/Tools/SurveysNursePhysicianAttitudesCommunicationCollaboration.aspx

These two surveys were developed by the Advocate Good Samaritan Hospital. The surveys can be used to better understand nurse and physician experiences with and attitudes about communicating/collaborating with each other and highlight areas that present the greatest opportunity for improvement.

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

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.ihi.org/resources/Pages/Changes/DecreaseDemandforAppointments.aspx

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.ihi.org/resources/Pages/Changes/MeasureandUnderstandSupplyandDemand.aspx

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

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

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 5 percent.

5. Optimize the Care Team
http://www.ihi.org/resources/Pages/Changes/OptimizetheCareTeam.aspx

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, including links to tools such as the practice supply worksheet.

6. Reduce Scheduling Complexity
http://www.ihi.org/resources/Pages/Changes/ReduceSchedulingComplexity.aspx

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. **Revamped Scheduling Systems Promote Access, Reduce No Shows, and Enhance Quality, Patient Satisfaction, and Revenues in Primary Care Practice**
http://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 post- implementation 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**
http://www.innovations.ahrq.gov/content.aspx?id=1868

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

Cross-reference to resource already described:

- General Resources, 2014 National Patient Safety Goals: Ambulatory Care.

Charts and Medical Records

1. **Electronic Medical Record-Facilitated Workflow Changes Enhance Quality and Efficiency, Generating Positive Return on Investment in Small Pediatrics Practice**
http://www.innovations.ahrq.gov/content.aspx?id=274

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

3. An Interactive Preventive Care Record: A Handbook for Using Patient-Centered Personal Health Records to Promote Prevention
http://healthit.ahrq.gov/sites/default/files/docs/page/PreventiveCareHandbook_062912comp.pdf

This handbook for primary care practice personnel, leaders, and informatics staff provides practical guidance on the implementation of interactive preventive health records (IPHRs). Through a step-by-step guide, the handbook can help a practice apply an IPHR to promote chronic disease management by:

- Using personal health records (PHRs) to promote prevention.
- Preparing your practice to use a PHR for promoting prevention.
- Implementing and sustaining the use of a PHR for prevention.

4. TransforMED[SM] Health Information Technology Resources
http://transformed.com/resources/HIT.cfm

TransforMED[SM] 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. Aurora Health Care Medication List Toolkit
http://www.consumersadvancingpatientsafety.org/caps/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. Automated Pharmacy Alerts Followed by Pharmacist-Physician Collaboration Reduce Inappropriate Prescriptions Among Elderly Outpatients
http://www.innovations.ahrq.gov/content.aspx?id=1780

This featured profile is available on the Agency for Healthcare Research and Quality'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.

3. How to Create an Accurate Medication List in the Outpatient Setting Through a Patient-Centered Approach

http://forces4quality.org/node/3432

This toolkit outlines the steps necessary to create a community-based, patient-centered medication reconciliation process and provides specific templates and resources such as:

- Project goals and objectives.
- Patient interview questions.
- Focus group questions.
- Health care provider interview questions.
- Time in motion study tool.
- Clinic process flowchart.
- Medication list evaluation form.
- Medication bag evaluation form.

4. ISMP List of High-Alert Medications in Community/Ambulatory Healthcare
http://www.ismp.org/communityRx/tools/highAlert-community.pdf

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

5. ISMP's List of Confused Drug Names
http://www.ismp.org/Tools/confuseddrugnames.pdf

Drawing on information gathered from the ISMP Medication Errors Reporting Program, this fact sheet 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.

6. Medication Reconciliation Toolkit
https://www.ncqualitycenter.org/wp-content/uploads/2013/01/MRToolkit.pdf

This medication reconciliation toolkit from the Department of Defense Patient Safety Program 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.

7. Medications At Transitions and Clinical Handoffs (MATCH) Initiative
http://www.nmh.org/nm/for-physicians-match

The goal of the 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. It provides a step-by-step guide to improving the medication reconciliation process and includes guidelines, flowcharts, modifiable templates, and lessons learned.

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

This featured profile is available on the Agency for Healthcare Research and Quality'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.

9. 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.

10. The PROTECT Initiative: Advancing Children's Medication Safety
http://www.cdc.gov/medicationsafety/protect/protect_initiative.html

The PROTECT Initiative is an innovative collaboration bringing together public health agencies, private sector companies, professional organizations, consumer/patient advocates, and academic experts to develop strategies to keep children safe from unintentional medication overdoses. Medication overdoses can lead to harm, sometimes requiring emergency treatment or hospitalization and are a significant public health problem. Over-the-counter and prescription medications are commonly used for people of all ages. This frequency of use increases the potential for unintentional overdoses. Children are especially vulnerable to unintentional overdoses, most of which can be prevented.

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

This featured profile is available on the Agency for Healthcare Research and Quality'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.

12. 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 process, and templates for communicating the launch to patients.

Diagnostics and Tests

1. 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.

2. 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-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
http://www.ihi.org/resources/Pages/Changes/CreateContingencyPlans.aspx

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
http://www.innovations.ahrq.gov/content.aspx?id=1748

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. Patient Encounter Form
http://sitemaker.umich.edu/clinfotracker/files/JaneDoe_PEF.jpg

This form 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.

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

This featured profile is available on the Agency for Healthcare Research and Quality'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 post- implementation 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. Coordinated-Transitional Care Toolkit

http://www.hipxchange.org/C-trac

This tool was developed by the University of Wisconsin-Madison School of Medicine & Public Health and the William S Middleton Memorial Veterans Hospital. The Coordinated-Transitional Care (C-TraC) Toolkit is a low-resource, telephone-based, protocol-driven program designed to reduce 30-day rehospitalizations and to improve care transitions during the early posthospital period. The goal of this toolkit is to help hospital systems that serve populations with high rates of patient dispersion, cognitive impairment, and vulnerability improve care coordination and postdischarge outcomes such as reduced medication discrepancies. The toolkit is designed to help clinicians and researchers execute the C-TraC program protocol. Highlights of the C-TraC program toolkit include the following:

- An overview of barriers to providing high-quality transitional care
- Core components of the C-TraC program protocol
- A step-by-step guide to executing the C-TraC program protocol
- An overview of common challenges to managing the C-TraC program protocol

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
http://www.innovations.ahrq.gov/content.aspx?id=1752

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-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
http://www.innovations.ahrq.gov/content.aspx?id=1785

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.ihi.org/resources/Pages/Changes/ManagePanelSizeandScopeofthePractice.aspx

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.ihi.org/resources/Pages/Changes/PredictandAnticipatePatientNeeds.aspx

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.ihi.org/resources/Pages/Changes/RecalibratetheSystembyWorkingDowntheBacklog.aspx

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:

- Dimension 9. Patient Safety and Quality Issues, Access to Care, 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
http://www.pcmh.ahrq.gov/

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 health care home, is a promising model for transforming the organization and delivery of primary care. This Web site provides policymakers and researchers with access to evidence-based resources about the medical home and its potential to transform primary care and improve the quality, safety, efficiency, and effectiveness of U.S. health care.

2. CAHPS® Clinician & Group Survey
https://cahps.ahrq.gov/surveys-guidance/cg/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® Clinician & Group Survey (CG-CAHPS®), including the questionnaire and administration guidelines, as well as reporting and benchmarking data.

3. CAHPS® Health Information Technology Item Set

https://cahps.ahrq.gov/surveys-guidance/item-sets/HIT/index.html

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.

4. CAHPS® Health Literacy Item Set

https://cahps.ahrq.gov/surveys-guidance/item-sets/literacy/index.html

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 the Agency for Healthcare Research and Quality's continuing efforts to encourage greater emphasis in the provider community on patient-centered care.

5. 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.

6. 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.

7. Patient- and Family-Centered Care Organizational Self-Assessment Tool
http://www.ihi.org/resources/Pages/Tools/PatientFamilyCenteredCareOrganizationalSelfAssessmentTool.aspx

This tool was developed by the Institute for Healthcare Improvement (in collaboration with the National Initiative for Children's Healthcare Quality and the Institute for Patient- and Family-Centered Care). The self-assessment tool allows organizations to understand the range and breadth of elements of patient- and family-centered care and to assess where they are against the leading edge of practice. Use this self-assessment tool to assess how your organization is performing in relation to specific components of patient- and family-centered care, or as a basis for conversations about patient-centeredness in the organization.

8. Patient-Centered Care Improvement Guide
http://www.ihi.org/resources/Pages/Tools/PatientCenteredCareImprovementGuide.aspx

This guide was developed by Planetree (in collaboration with Picker Institute). The guide is designed as a practical resource for health care organizations that are striving to become more patient centered. It contains best practices and practical implementation tools contributed by hospitals from across the United States. The Self-Assessment Tool can help identify and prioritize opportunities for introducing patient-centered approaches into your organization.

9. Patient-Centered Primary Care Collaborative
http://www.pcpcc.org/

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.

10. 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.

11. 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.

Cross-reference to resource already described:

- Dimension 9. Patient Safety and Quality Issues, Medication, How to Create an Accurate Medication List in the Outpatient Setting Through a Patient-Centered Approach.

Effective

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

http://www.innovations.ahrq.gov/content.aspx?id=1882

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.

2. **Team-Based Ownership Over Defined Patient Panels Supported by Information Technology Enhances Provision of Evidence-Based Care**

http://www.innovations.ahrq.gov/content.aspx?id=1699

This featured profile is available on the Agency for Healthcare Research and Quality'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. **Revised Processes Related to Daily Opening Reduce Wait Times and Enhance Patient Satisfaction at Two Urban Clinics**

http://innovations.ahrq.gov/content.aspx?id=1904

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 resources already described:

- Dimension 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
http://innovations.ahrq.gov/content.aspx?id=1807

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. Eliminating Waste Without Hurting Quality
http://www.ihi.org/resources/Pages/Publications/EliminatingWasteWithoutHurtingQuality.aspx

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 Institute for Healthcare Improvement Web page provides information about eliminating waste.

3. Going Lean in Health Care
http://www.ihi.org/resources/Pages/IHIWhitePapers/GoingLeaninHealthCare.aspx

This is a white paper on the Institute for Healthcare Improvement 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.

4. Improve Workflow and Remove Waste
http://www.ihi.org/resources/Pages/Changes/ImproveWorkFlowandRemoveWaste.aspx

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.

5. Patient Cycle Tool
http://www.ihi.org/resources/Pages/Tools/PatientCycleTool.aspx

The Patient Cycle Tool is available through the Institute for Healthcare Improvement 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 Database
http://healthit.ahrq.gov/health-it-tools-and-resources/time-and-motion-studies-database

Measuring the impact 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 and practice managers use time and motion study data to evaluate whether and to what extent health information technology applications, including computerized provider order entry, electronic prescribing, and electronic health records, increase efficiency, such as helping clinicians perform routine tasks faster.

Equitable

1. 2012 National Healthcare Disparities Report
http://nhqrnet.ahrq.gov/inhqrdr/reports/nhdr

This report is featured on the Agency for Healthcare Research and Quality's Web site. The purpose of the National Healthcare Disparities Report is to identify differences in quality of and access to care between populations and to track how these gaps are changing over time. This report measures trends in effectiveness of care, patient safety, timeliness of care, patient-centeredness, and efficiency of care. The report presents expanded analyses on long-term trends in performance, regional and State differences in quality, and health care disparities for granular ethnicity categories. It also addresses six priority areas for quality improvement, as identified in the *National Strategy for Quality Improvement in Health Care*, and presents novel strategies for improving quality and reducing disparities from AHRQ's Health Care Innovations Exchange.

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

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. Oral, Linguistic, and Culturally Competent Services: Guides for Managed Care Plans
http://www.ahrq.gov/professionals/systems/primary-care/cultural-competence-mco/index.html

To address shifting demographic trends in health care, two guides offer approaches to defining cultural needs in managed care and developing appropriate services for them. The Centers for Medicare & Medicaid Services (CMS) commissioned both guides, which were developed by a contractor of the Agency for Healthcare Research and Quality (AHRQ).

5. Plan-Funded Team Coordinates Enhanced Primary Care and Support Services to At-Risk Seniors, Reducing Hospitalizations and Emergency Department Visits
http://www.innovations.ahrq.gov/content.aspx?id=2243

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.