



AGENCY FOR HEALTHCARE RESEARCH AND QUALITY

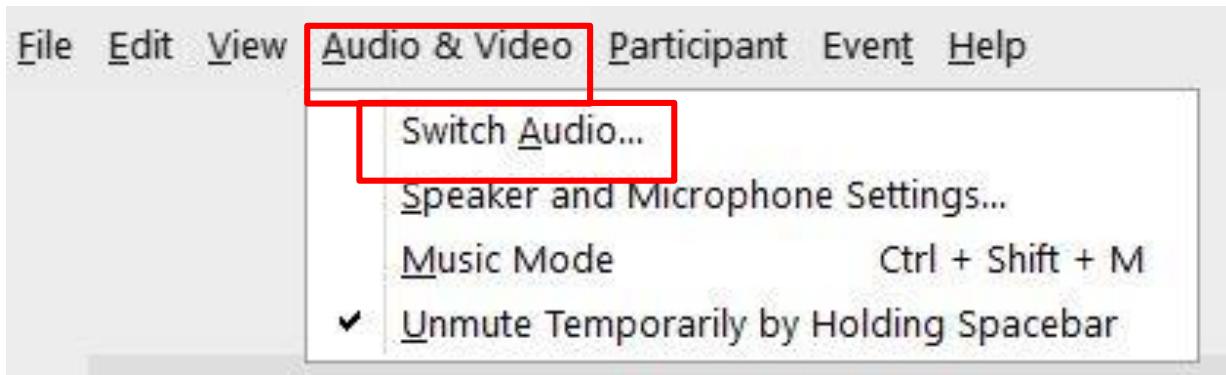


# New AHRQ SOPS® Diagnostic Safety Supplemental Items for Medical Offices

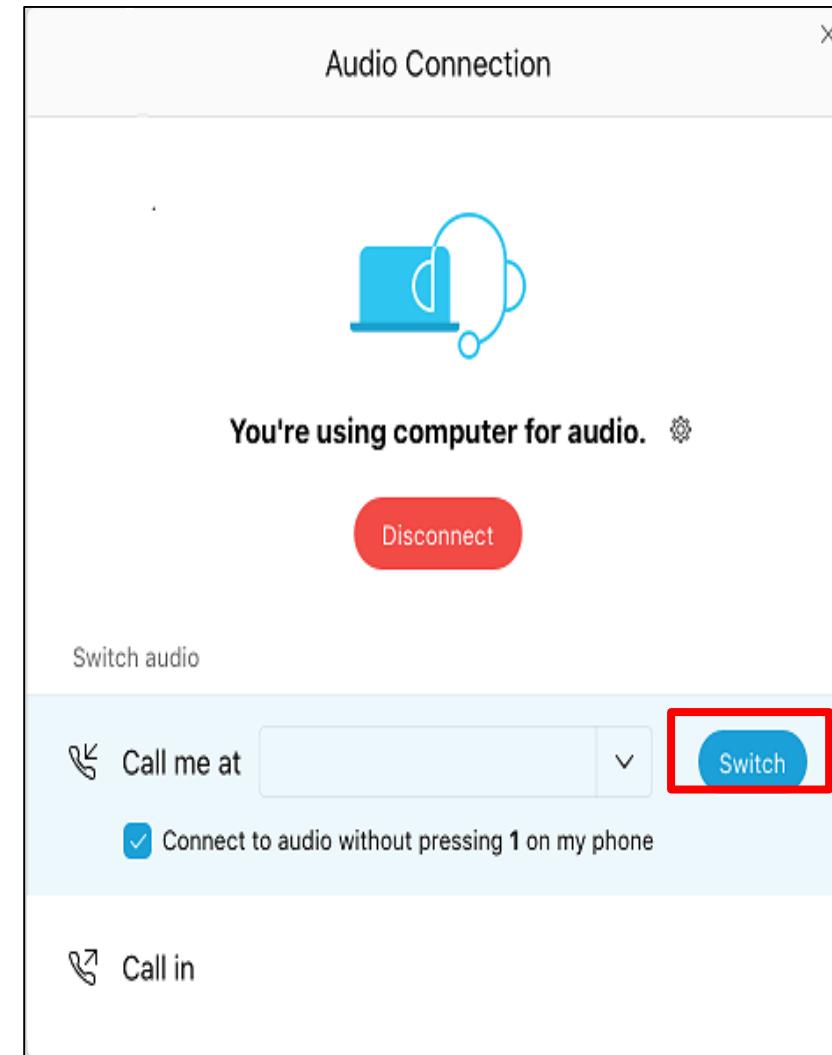
**Webcast**  
**June 2, 2021**  
**1:00-2:00 PM ET**

# Need Help?

- No sound from computer speakers?

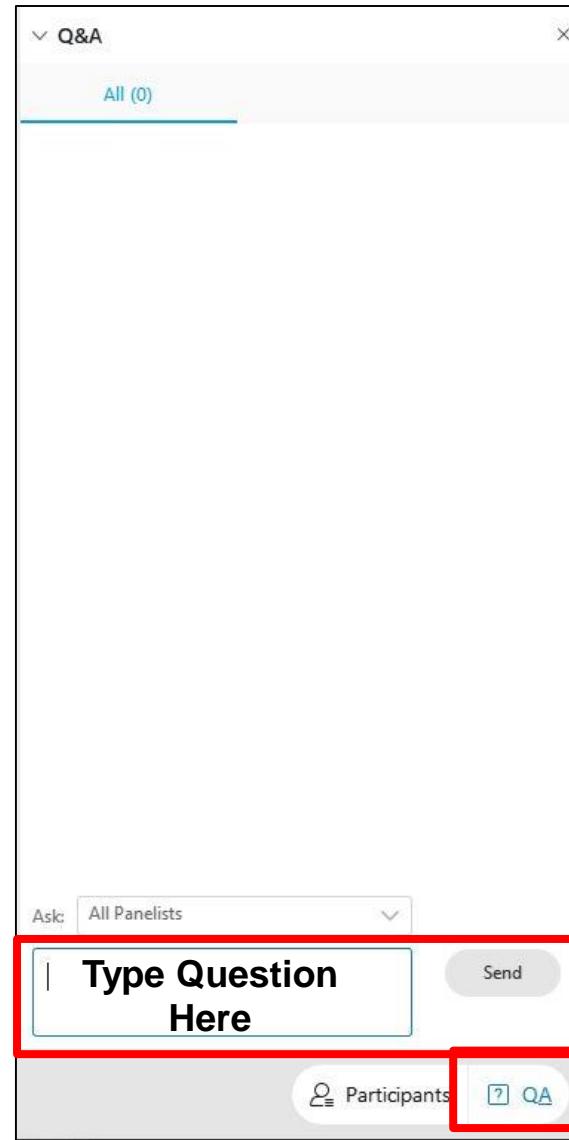


- Trouble with your connection or slides not moving?
  - ▶ Log out and log back in
- Other problems?
  - ▶ Use Q&A feature to ask for help



# How to Ask a Question

- Question and Answer
  - ▶ Select Q&A
  - ▶ Type question in the box that opens
  - ▶ Make sure “All Panelists” is selected

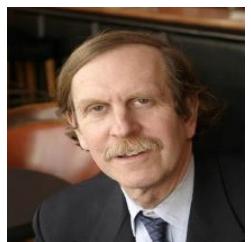


# Today's Speakers



## **Caren Ginsberg, Ph.D.**

Director, SOPS and CAHPS Programs  
Center for Quality Improvement and Patient Safety  
Agency for Healthcare Research and Quality (AHRQ)



## **Gordon Schiff, M.D.**

General Internist and Quality and Safety Director  
Harvard Medical School Center for Primary Care



## **Naomi Yount, Ph.D.**

User Network for the AHRQ Surveys on Patient Safety Culture (SOPS)  
Westat



## **Joann Sorra, Ph.D. (Moderator)**

User Network for the AHRQ Surveys on Patient Safety Culture (SOPS)  
Westat

# Agenda



- Overview from AHRQ
- Background and Importance of Diagnostic Safety
- Overview of the SOPS Diagnostic Safety Supplemental Items
- Q&A

# AHRQ's Surveys on Patient Safety Culture™ (SOPS®) Program



**Caren Ginsberg, Ph.D.**

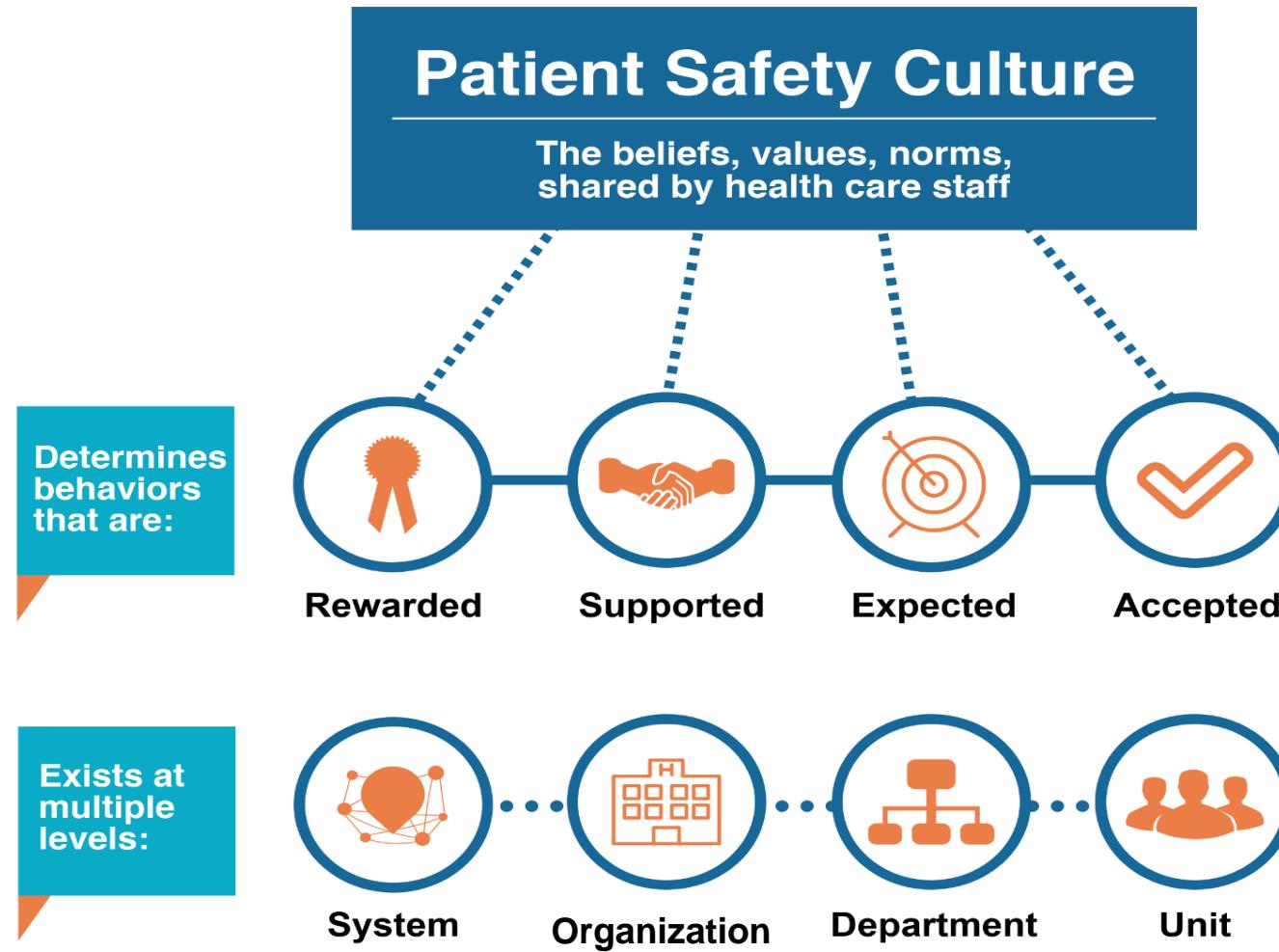
Center for Quality Improvement and Patient Safety, AHRQ

# AHRQ's SOPS Program



- Initiated and funded by AHRQ since 2001 to advance the understanding, measurement, and improvement of patient safety culture within healthcare settings
- Develops survey measures that are validated and use best methods for development and testing
- Supports voluntary data submission to SOPS databases
- Conducts research to further...
  - ▶ the measurement and understanding of patient safety culture
  - ▶ the collection of data and informative reporting of patient safety culture data
  - ▶ patient safety improvement involving SOPS

# What is Patient Safety Culture?



# What are the SOPS Surveys?



- Surveys of providers and staff about the extent to which their organizational culture supports patient safety



# Areas of Patient Safety Culture Assessed Across SOPS Surveys



- Teamwork
- Communication Openness
- Communication About Error
- Organizational Learning—Continuous improvement
- Response to Error
- Staffing
- Supervisor/Management Support for Patient Safety
- Work Pressure and Pace
- Overall Rating on Patient Safety

# How are SOPS surveys used?



- Raise staff awareness about patient safety
- Assess patient safety culture to identify strengths and areas for improvement
- Examine trends over time
- Evaluate the impact of patient safety initiatives



# SOPS Surveys and Supplemental Item Sets



SOPS Surveys	SOPS Supplemental Item Sets			
	Value and Efficiency	Health Information Technology	Diagnostic Safety	Workplace Safety (expected 2021)
Hospital	✓	✓		✓
Medical Office	✓		✓	
Nursing Home				
Ambulatory Surgery Center				
Community Pharmacy				

# Background and importance of diagnostic safety: Culture of diagnostic safety in medical offices

**Gordon (Gordy) Schiff, MD**

Associate Director Center for Patient Safety Research and Practice  
Brigham and Women's Hospital Div. General Medicine

Safety Director – Harvard Center for Primary Care  
Academic Improvement Collaborative

Associate Professor of Medicine Harvard Medical School

**BRIGHAM HEALTH**



BRIGHAM AND WOMEN'S  
Department of Medicine



**CENTER FOR  
PRIMARY CARE**  
HARVARD MEDICAL SCHOOL



**HARVARD  
MEDICAL SCHOOL**

Global and Continuing  
Education

# The US Agency for Healthcare Research and Quality's activities in patient safety research

GREGG S. MEYER<sup>1,3</sup>, JAMES BATTLES<sup>2</sup>, JAMES C. HART<sup>2</sup> AND NING TANG<sup>3</sup>

<sup>1</sup>Massachusetts General Physicians Organization, Boston, MA, <sup>2</sup>Center for Quality Improvement and Patient Safety, Agency for Healthcare Research and Quality, Rockville, MD, <sup>3</sup>Harvard Medical School, Boston, MA, USA

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## Abstract

**Purpose.** To update the international community on the US Agency for Healthcare Research and Quality's (AHRQ) recent and current activities in improving patient safety.

**Data sources.** Review of the literature concerning the importance of patient safety as a health care quality issue, international perspectives on patient safety, a review of research solicitations, and early results of funded studies.

**Study selection.** A representative sample of patient safety studies from those currently being funded by AHRQ.

**Results.** In response to a growing interest in patient safety in general and a recent US Institute of Medicine report on patient safety in particular, the US Agency for Healthcare Research and Quality has refocused its quality research mission. In the fiscal year 2002, AHRQ spent US\$55 million on patient safety research. This investment was spread across six complementary research areas: (1) health systems error reporting, analysis, and safety improvement research demonstrations; (2) Clinical Informatics to Promote Patient Safety (CLIPS); (3) Centers of Excellence for patient safety research and practice (COE); (4) Developmental Centers for Evaluation and Research in Patient Safety (DCERPS); (5) The Effect of Health Care Working Conditions on Quality of Care; and (6) Partnerships for Quality: Patient Safety Research Dissemination and Education. Internal teams of researchers at AHRQ have published studies on patient safety, such as documenting the impact of medication errors. In addition to funding research on patient safety, AHRQ is an integral partner in several national and international collaborations to form strategic synergies that build upon each member organization's strengths, reduce redundant efforts, and

# The US Agency for Healthcare Research and Quality's activities in patient safety research

GREGG S. MEYER<sup>1,3</sup>, JAMES BATTLES<sup>2</sup>, JAMES C. HART<sup>2</sup> AND

<sup>1</sup>Massachusetts General Physicians Organization, Boston, MA, <sup>2</sup>Center for Health Services and Technology Evaluation, Agency for Healthcare Research and Quality, Rockville, MD, <sup>3</sup>Harvard Medical School, Boston, MA

Only 1 of 93 initial AHRQ Safety Grants focused on Diagnostic Errors

## Abstract

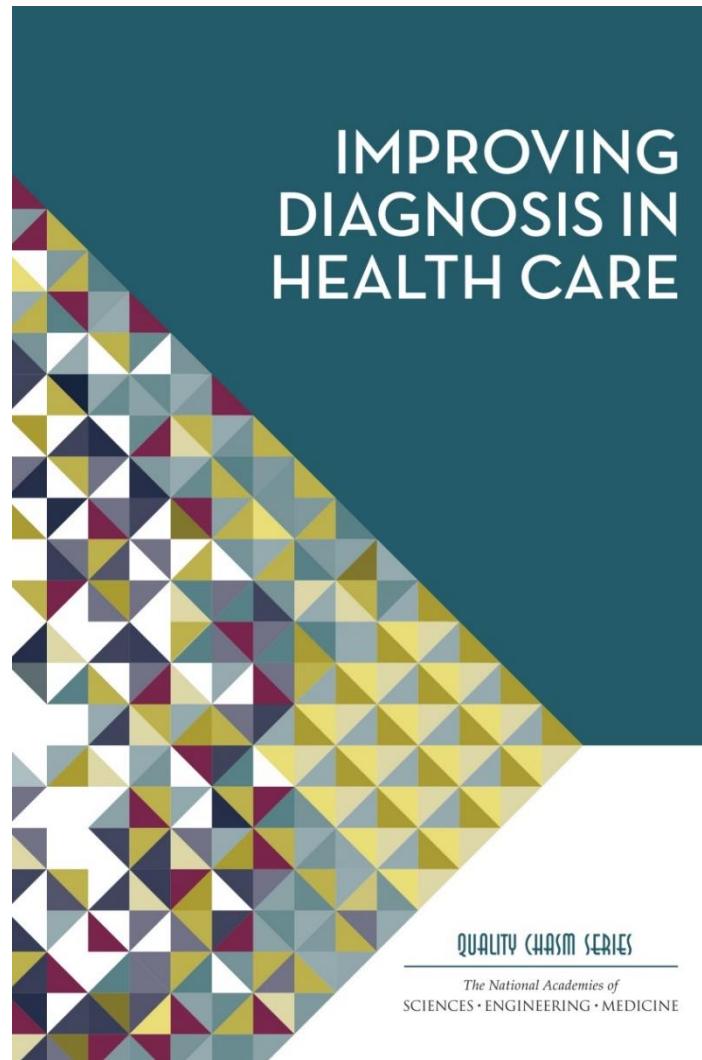
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# IOM Report September 2015



# Diagnosis Errors are...

- Frequent
- Important
- Overlooked
- Matter
- Not easy to measure

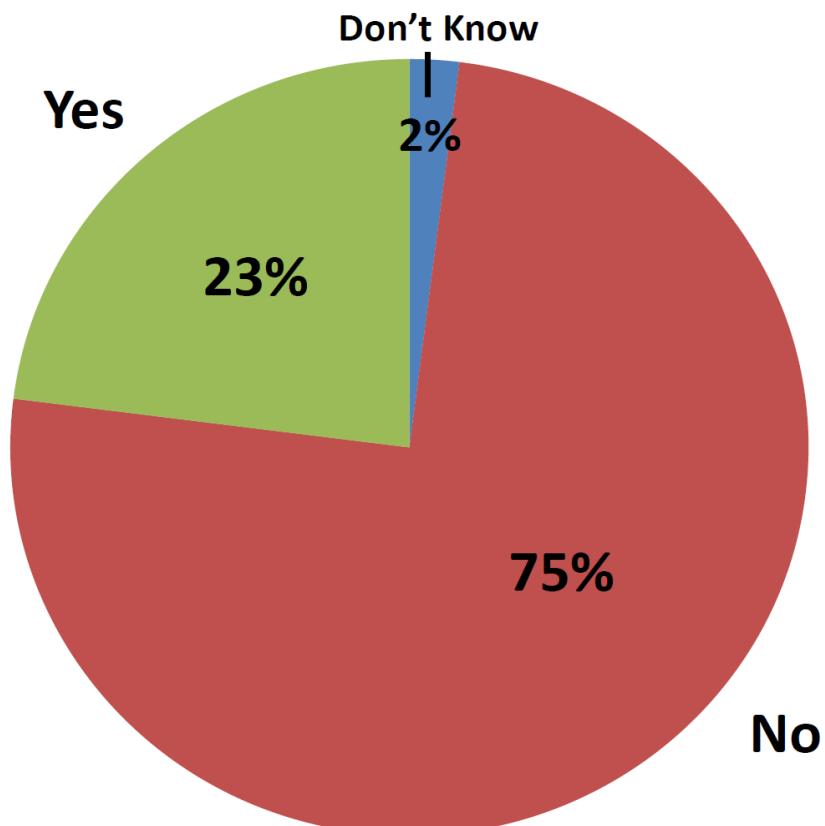
# Frequent - #1 Type of Errors

- Patient reports
- Malpractice claims
  - Particularly in ambulatory setting
- Safety experts' ranking

# MA Residents Involved in a Medical Error Situation



*% saying personally involved in a situation where a preventable medical error was made in their own care or in the care of someone close to them*



# Most Common Types of Medical Error Experienced by MA Residents



for Patient Safety and Medical Error Reduction

% saying...

*(Among the 23% who said they or a person close to them experienced a medical error)*

Your/their medical problem was misdiagnosed



51%

You/they were given the wrong test, surgery, or treatment



38%

You were given wrong or unclear instructions about your follow-up care



34%

You/they were given an incorrect medication, meaning the wrong dose or wrong drug



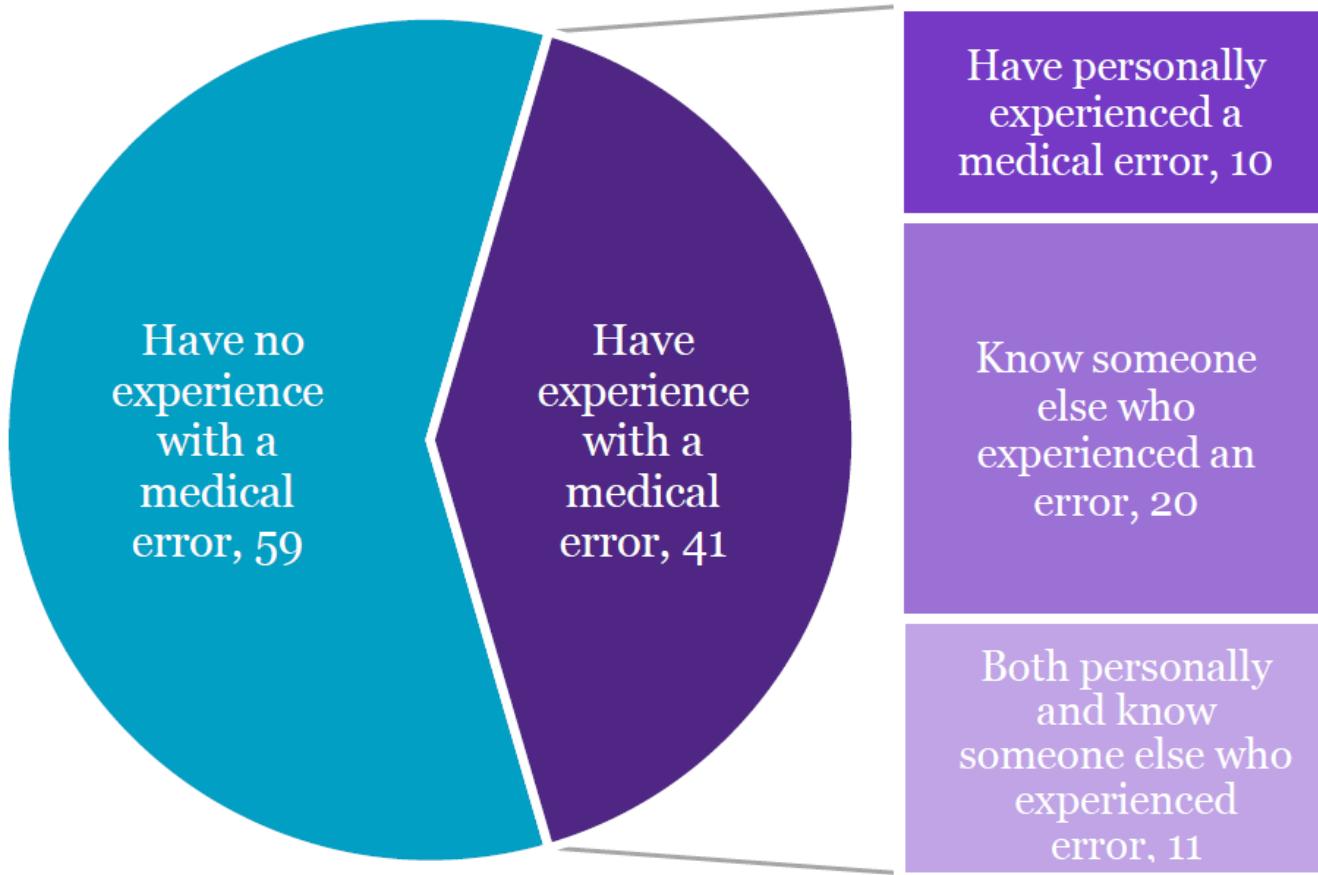
32%

You/they got an infection as a result of your/their test, surgery, or treatment

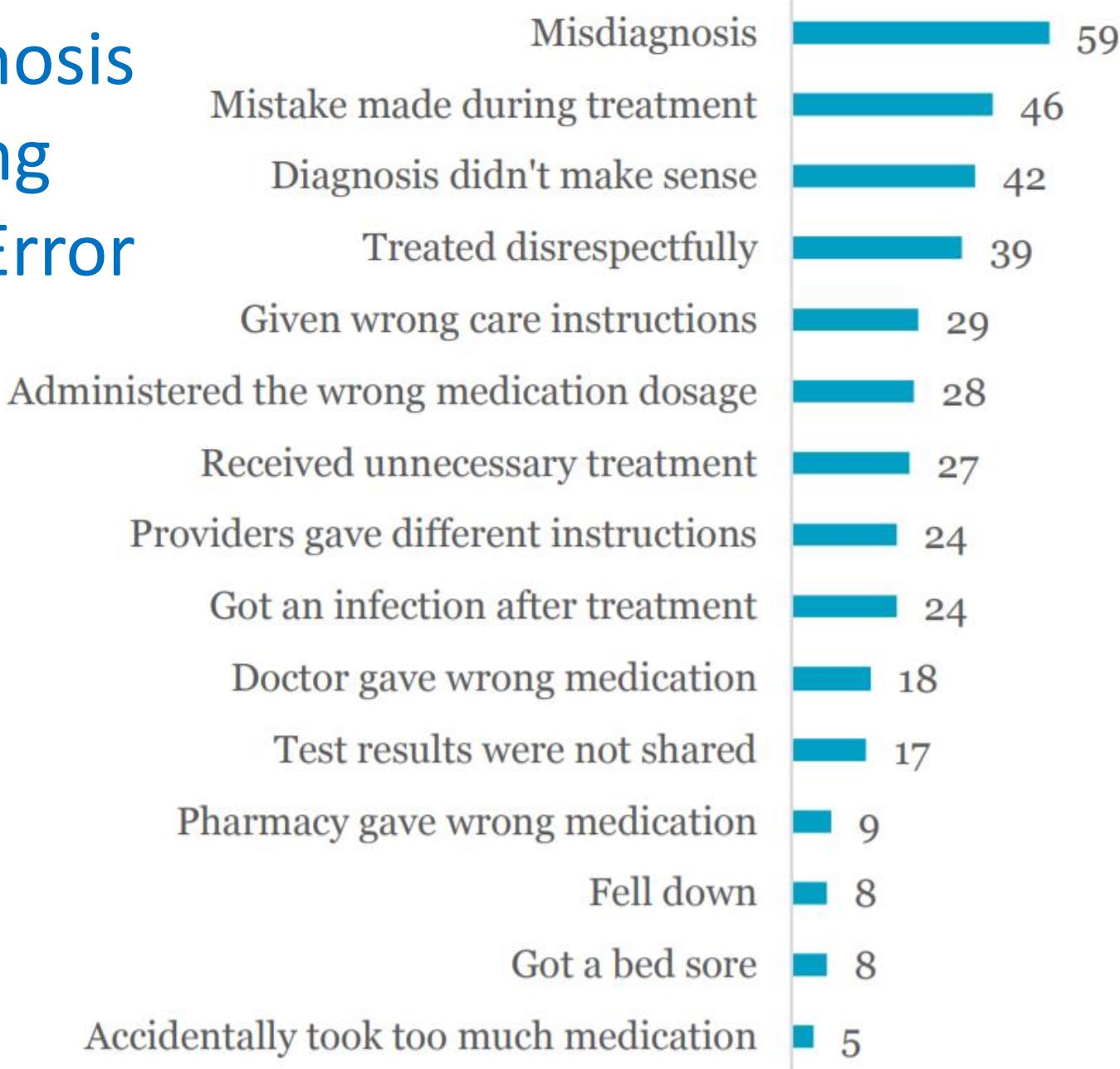


32%

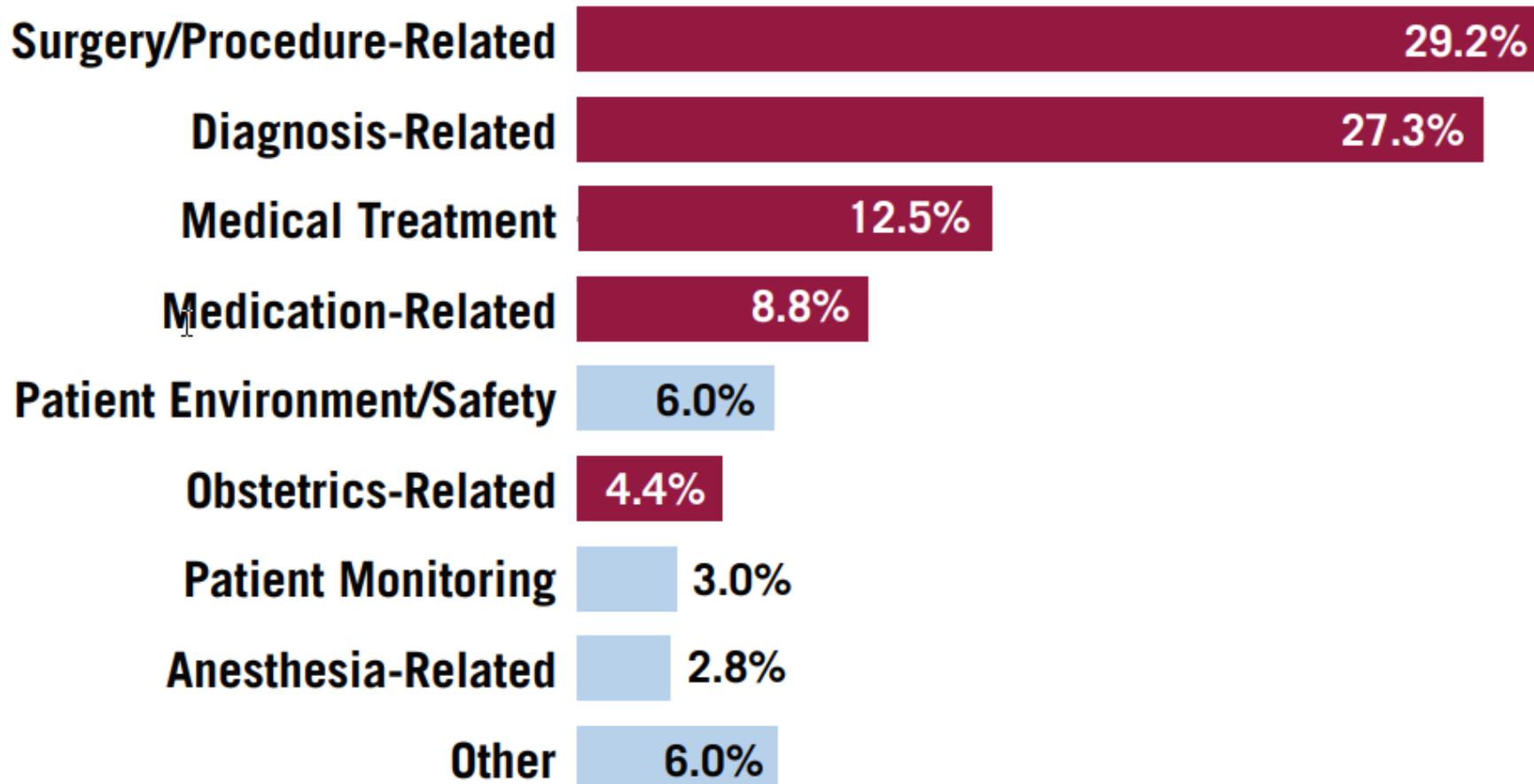
# 21% Experienced Medical Error



# Misdiagnosis Leading Type of Error



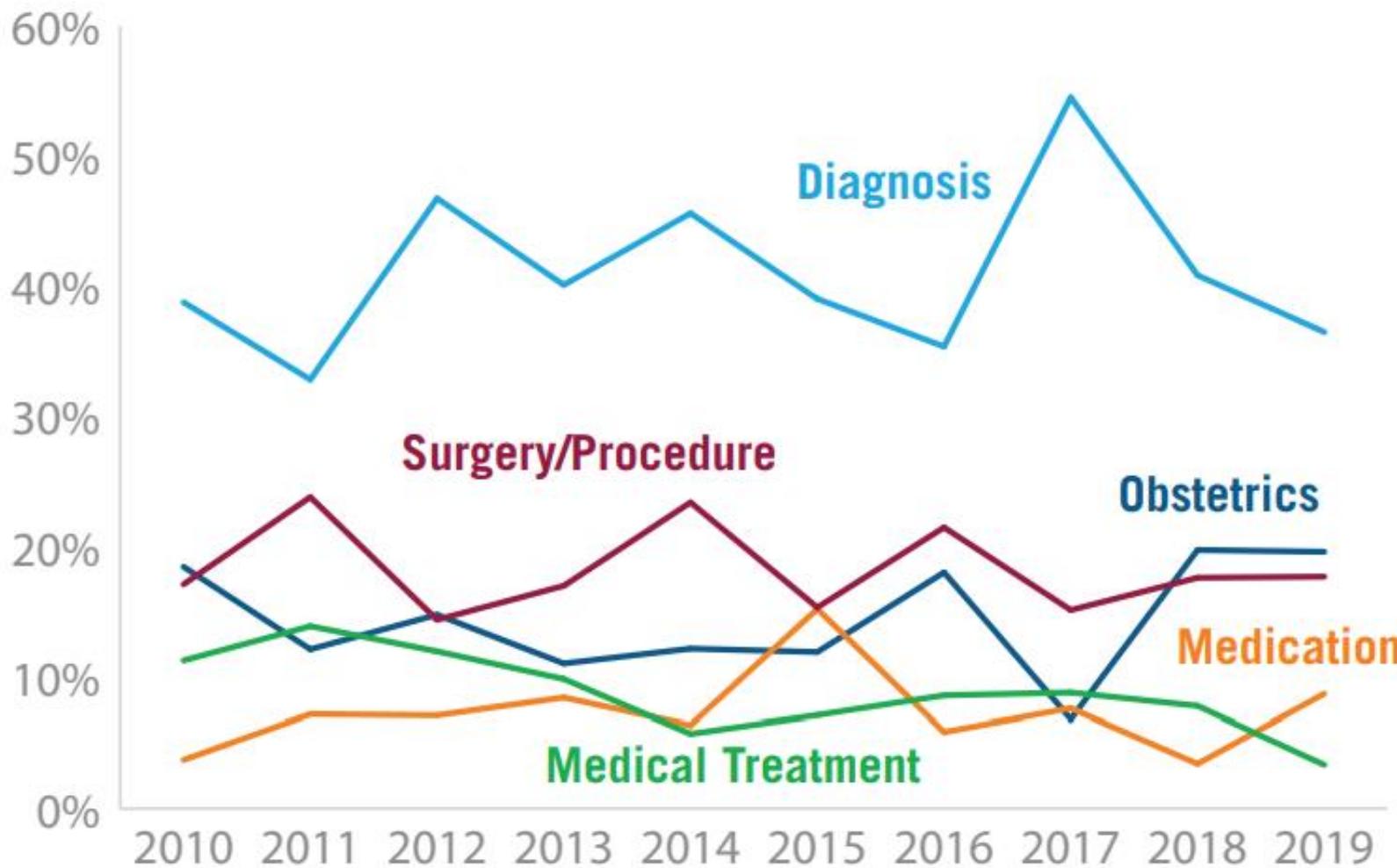
# Top Allegation Types



N = 11,907 events closed between 2010-2019.

# Closed With Indemnity Paid

## Top 5 Allegation Types



# Cases Closed: Allegations by Close Year

	2005	2006	2007	2008	2009	<b>TOTAL</b>
Diagnosis-related	72	82	79	83	81	397
Medication-related	11	13	14	14	16	68
Medical Treatment	14	4	10	8	5	41
Communication	2	4	1	5	3	15
Violation of Rights	5	0	2	3	1	11
Safety & Security	0	2	1	2	3	8
OB-related Treatment	2	2	0	0	2	6
Surgical Treatment	1	1	0	1	0	3
Breach of Confidentiality	1	1	0	0	0	2
<b>Total Number of Cases</b>	<b>108</b>	<b>109</b>	<b>107</b>	<b>116</b>	<b>111</b>	<b>551</b>

N=551 CRICO and Coverys outpatient PL cases closed 2005–2009 naming General Medicine staff/fellow physicians (excl. Hospitalists) and excluding ED locations.



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evidence-based care.

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# 2018 Top Patient Safety Concerns



1. Diagnostic errors
2. Opioid safety across the continuum of care
3. Care coordination within a setting
4. Workarounds
5. Incorporating health IT into pt safety programs
6. Management behavioral health in acute care
7. All-hazards emergency preparedness
8. Device cleaning, disinfection, and sterilization
9. Patient engagement and health literacy
10. Leadership engagement in patient safety

# 2019 Top 10 Patient Safety Concerns



1. Diagnostic Stewardship & Test Result Management Using EHRs
2. Antimicrobial Stewardship
3. Burnout and Its Impact on Patient Safety
4. Patient Safety Concerns Involving Mobile Health
5. Reducing Discomfort with Behavioral Health
6. Detecting Changes in a Patient's Condition
7. Developing and Maintaining Skills
8. Early Recognition of Sepsis across the Continuum
9. Infections from Peripherally Inserted IV Lines
10. Standardizing Safety Efforts across Large Systems

# 2019 Top 10 Patient Safety Concerns



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# 2020 Top 10 Patient Safety Concerns



1. Missed and Delayed Diagnoses
2. Maternal Health across the Continuum
3. Early Recognition of Behavioral Health Needs
4. Device Problems
5. Device Cleaning, Disinfection, and Sterilization
6. Standardizing Safety across the System
7. Patient Matching in the EHR
8. Antimicrobial Stewardship
9. Overrides of Automated Dispensing Cabinets
10. Fragmentation across Care Settings

# Overlooked/neglected: Why?

- Hard to define/agree on “error”
  - Is it a shortcoming in diagnostic process...
  - Or is it getting/giving the “wrong diagnosis”
- How to even know whether diagnosis was right or wrong?
  - Spotty follow-up
  - Most diagnoses resolve,...or evolve w/errors unnoticed
- Elusive to capture with “metrics”
  - *Immature* measures for rating cases, docs, organizations
  - So much variation in disease, patient, hard to fairly measure, adjust, compare, make judgments
- Defy easy “fixes”
  - Humans hard-wired to use heuristics, succumb to biases
  - Technical fixes to date not magic bullets



Resources

## Improvement Stories



SHARE

How to Improve

Measures

Changes

Improvement  
Stories

Tools

Publications

IHI White Papers

Audio and Video

Case Studies

### The Five Rights of Medication Administration

by Frank Federico, RPh, Executive Director, Institute for Healthcare Improvement

One of the recommendations to reduce medication errors and harm is to use the "five rights": the right patient, the right drug, the right dose, the right route, and the right time. When a medication error does occur during the administration of a medication, we are quick to blame the nurse and accuse her/him of not completing the five rights. The five rights should be accepted as a goal of the medication process not the "be all and end all" of medication safety.

Judy Smetzer, Vice President of the Institute for Safe Medication Practices (ISMP), writes, "They are merely broadly stated goals, or desired outcomes, of safe medication practices that offer no procedural guidance on how to achieve these goals. Thus, simply holding healthcare practitioners accountable for giving the right drug to the right patient

### MORE ON

Prioritizing Pe...  
Times of Crisis  
to Support He...  
COVID-19 Par...

How to Safely  
After a COVID...

A Guide to Pr...  
Workforce We...  
COVID-19 Par...

Workforce Sa...

Telemedicine:

### FEATURED



**5  
RIGHTS**

Patient

Drug

Dose

Time

Route

Improving medication safety

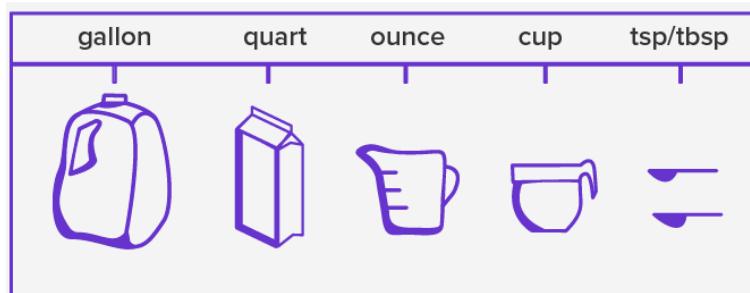
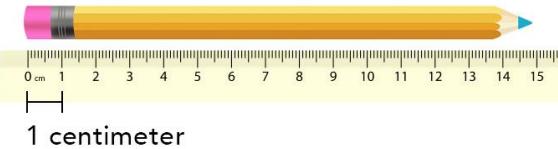
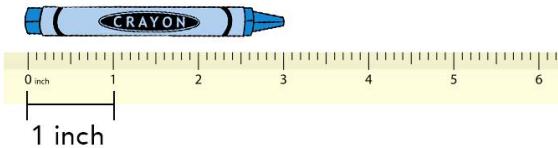


But if DIAGNOSIS is WRONG  
treatment likely is Not Right

Improving medication safety



# Instruments to Measure



# Self-Measurement/Learning Tools

- Guiding light, beacon to see way forward in the dark
- Not *metric* to be “gamed” but *mirror* to better see how doing and ways to improve and monitor progress

*When I walk into a workplace and see workers measuring themselves...I see quality*

Avedis Donabedian



# AHRQ SOPS Surveys

- 2-decade track record of meaningful validated self assessment
- Creative combining of specific process questions and overall safety climate



The screenshot shows the AHRQ website header with the AHRQ logo and navigation links for Topics, Programs, Research, Data, Tools, Funding & Grants, News, and About. Below the header, a purple banner indicates the current page is "Surveys on Patient Safety Culture™ (SOPS®)". The main content area displays a graphic titled "SOPS Feedback Report" showing horizontal bars for "Your Results" (red) and "Database Results" (blue). A question mark icon is placed over one of the bars. An illustration of a man in a suit is visible on the right. At the bottom left, there is a URL: [www.ahrq.gov/sops/database/index.html](http://www.ahrq.gov/sops/database/index.html).



# Diagnostic Safety Supplemental Items

- Amazing discussions, disagreements, breakthroughs, insights, compromises among respected expert colleagues
- Not easy to draft nor perfect, but state-of-the art best consensus

## Your Medical Office's Processes Around Diagnosis

The following items ask about your medical office's processes around diagnosis. The processes start when a patient seeks care for a health problem, and include:

- Gathering, integrating, and interpreting information about the patient (e.g., clinical history, physical exam, test and imaging results, referrals),
- Making an initial diagnosis,
- Discussing the diagnosis with the patient, and
- Following up with the patient and revising the diagnosis over time, as needed.

### SECTION A: Time Availability

How much do you agree or disagree with the following statements?	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree	Does Not Apply or Don't Know
1. The amount of time for appointments is long enough to fully evaluate the patient's presenting problem(s) .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 9
2. Providers in this office have enough time to review the relevant information related to the patient's presenting problem(s).....  I	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 9
3. Providers in this office finish their patient notes by the end of their regular workday .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 9

### SECTION B: Testing and Referrals

How much do you agree or disagree with the following statements?	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree	Does Not Apply or Don't Know
1. This office is effective at tracking a patient's test results from labs, imaging, and other diagnostic procedures.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 9
2. When this office doesn't receive a patient's test results, staff follow up.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 9
3. All test results are communicated to patients, even if the test results are normal .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 9

# **Diagnostic Safety Supplemental Items for the SOPS Medical Office Survey**

**Naomi Yount, PhD**

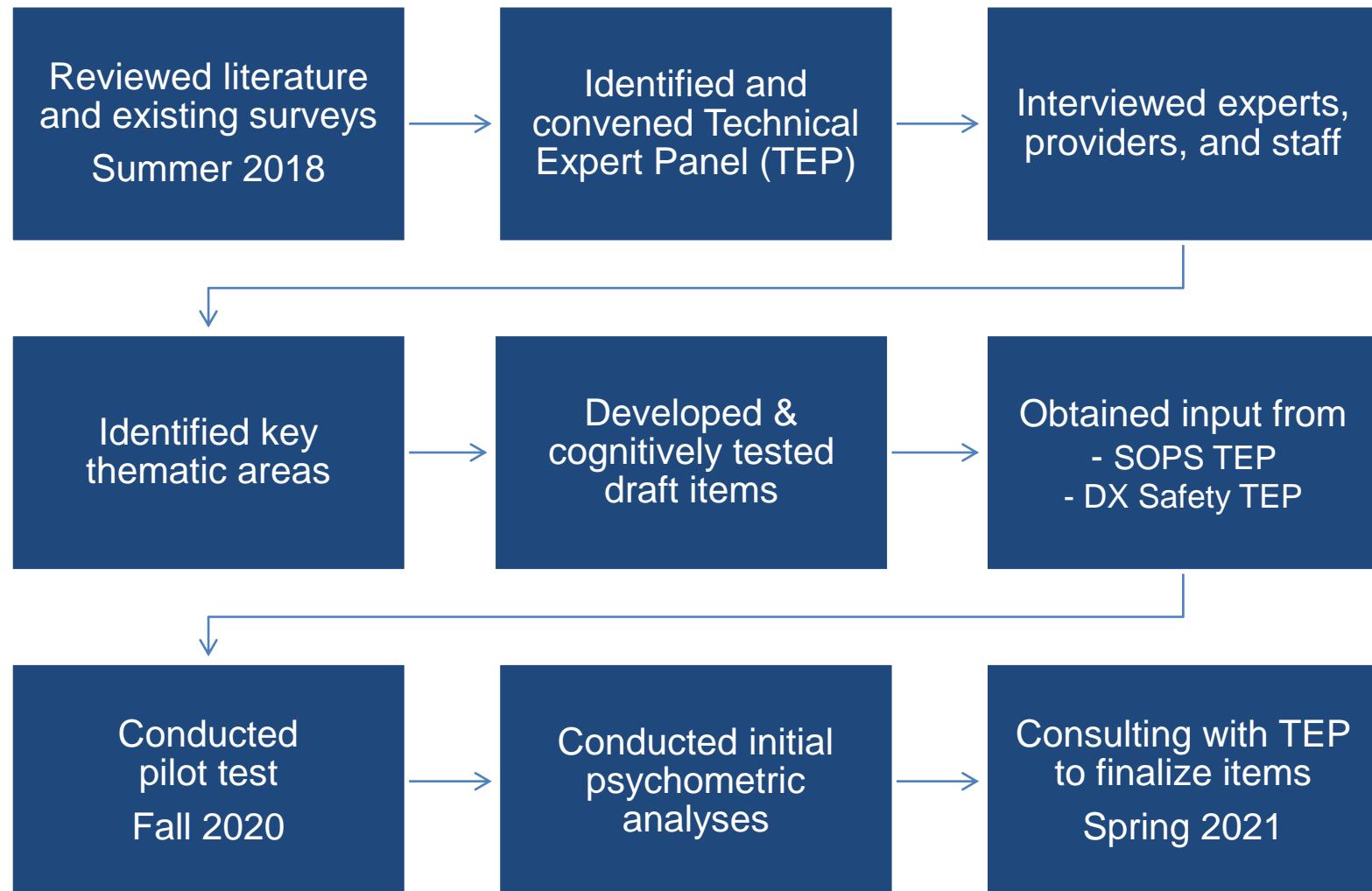
Westat

# Diagnostic Safety Supplemental Items



- Designed as a supplemental item set that can be added to the end of the SOPS Medical Office Survey
- Aims of the item set:
  - ✓ Raise awareness about diagnostic safety
  - ✓ Assess the extent to which the organizational culture supports the diagnostic process and accurate diagnoses
  - ✓ Help medical offices identify processes that need improvement and sources of error in diagnosis

# Survey Development Process



# Diagnostic Safety Technical Expert Panel Members



**Kelly Gleason**



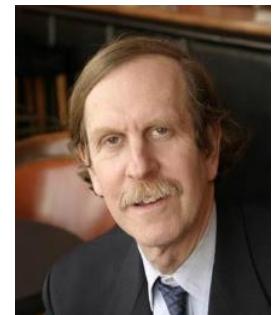
**Mark Graber**



**David Newman-Toker**



**Gordy Schiff**



**Hardeep Singh**



# What areas are assessed on the SOPS Medical Office Survey?



- Ten composite measures:
  1. Communication About Error
  2. Communication Openness
  3. Office Processes and Standardization
  4. Organizational Learning
  5. Overall Perceptions of Patient Safety and Quality
  6. Owner/Managing Partner/Leadership Support
  7. Patient Care Tracking/Followup
  8. Staff Training
  9. Teamwork
  10. Work Pressure and Pace
- Information exchange with other settings
- List of patient safety and quality issues
- Overall ratings on quality and patient safety

# What areas of diagnostic safety are assessed?



Three composite measures, or groups of items assessing specific areas of diagnostic safety:

- ▶ Time Availability (3 items)
- ▶ Testing and Referrals (4 items)
- ▶ Provider and Staff Communication Around Diagnosis (5 items)

# Pilot Study in Medical Offices



# What were the goals of the pilot study?

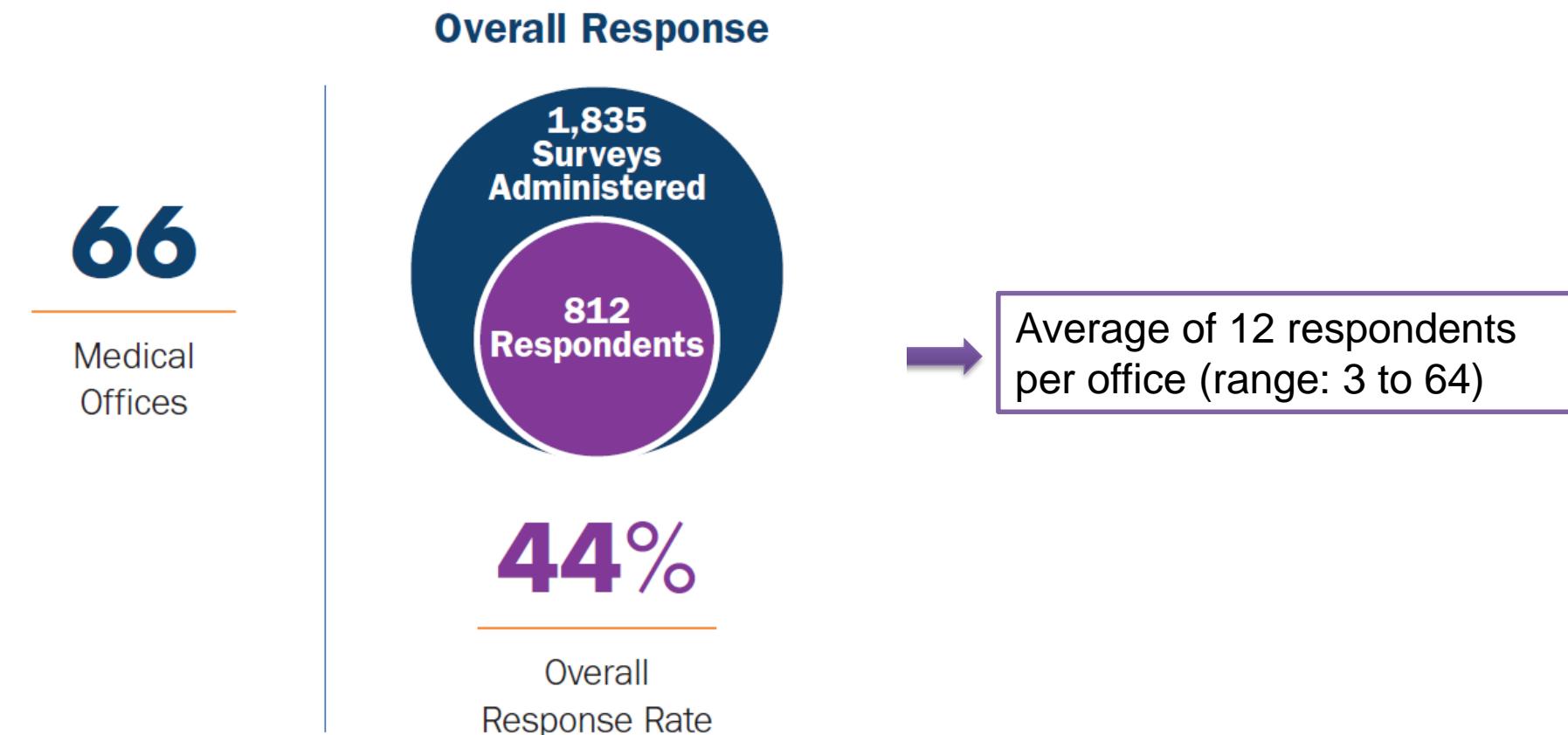


- ✓ Test the new diagnostic safety items in medical offices
- ✓ Conduct psychometric analysis of the pilot results to examine the reliability and construct validity of the items, retaining only the best items

# Fall 2020 Pilot Study



- Web-based survey to all providers and staff



# Participating Medical Offices

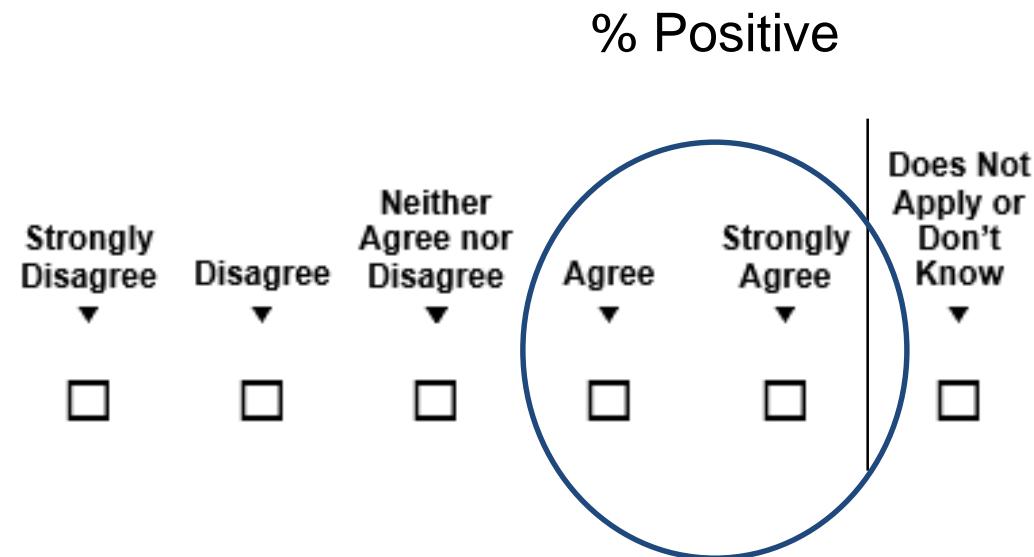
- 79% of medical offices were owned by a hospital or health system, university or academic medical center
- 65% were single specialty offices
  - 56% of the single specialty offices were Primary Care, Internal Medicine, Family Practice, Family Medicine
- 48% had 4-9 physicians/PAs/NPs



# Results

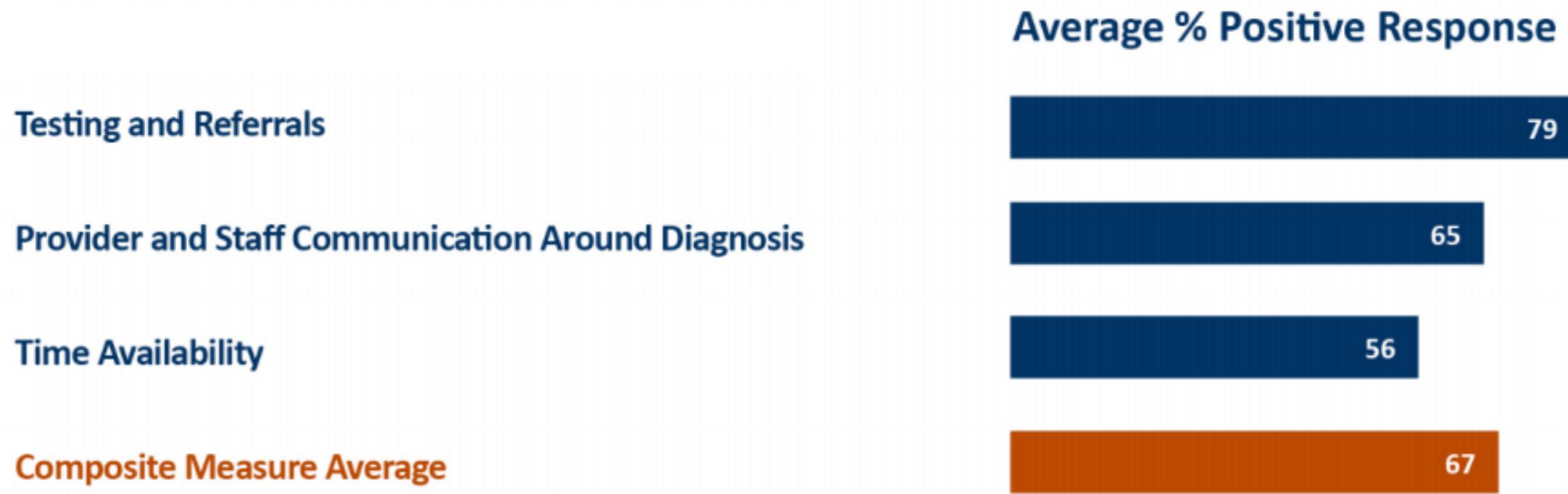
- Results shown as “percent positive scores”

*When this office doesn't receive a patient's test results, staff follow up.*



% Positive does not include “Does Not Apply or Don’t know” (NA/DK) or missing (MI) responses.

# Composite Measure Results



# Testing and Referrals Results



All test results are communicated to patients, even if the test results are normal.

This office is effective at tracking a patient's test results from labs, imaging, and other diagnostic procedures.

When this office doesn't receive a patient's test results, staff follow up.

When this office makes a high priority referral, we try to confirm whether the patient went to the appointment.

## Average % Positive Response



# Provider and Staff Communication Around Diagnosis Results



## Average % Positive Response

Providers in this office talk directly with specialists/radiologists/pathologists when something needs clarification.

86

Providers in this office encourage staff to share their concerns about a patient's health condition.

74

Providers document differential diagnoses when they have not ruled out other diagnoses.

57

When a provider thinks another provider in this office/system may have missed a diagnosis, they inform that provider.

55

When a missed, wrong, or delayed diagnosis happens in this office, we are informed about it.

53

# Provider and Staff Communication Around Diagnosis Results



## Average % Positive Response

Providers in this office talk directly with specialists/radiologists/pathologists when something needs clarification.

86

Providers in this office encourage staff to share their concerns about a patient's health condition.

74

Providers document differential diagnoses when they have not ruled out other diagnoses. (NA/DK/MI = 48%)

57

When a provider thinks another provider in this office/system may have missed a diagnosis, they inform that provider. (NA/DK/MI = 49%)

55

When a missed, wrong, or delayed diagnosis happens in this office, we are informed about it. (NA/DK/MI = 43%)

53

# Time Availability Results



Providers in this office have enough time to review the relevant information related to the patient's presenting problem(s).

The amount of time for appointments is long enough to fully evaluate the patient's presenting problem(s).

Providers in this office finish their patient notes by the end of their regular workday.

## Average % Positive Response



# Open-ended Comments



## Testing and Referrals

It is **difficult...to stay on top of all the open orders (labs and imaging)...referrals and faxes** we should be receiving. It would be **nice to have a more standardized workflow** to close these gaps

I know in my field I **never have time to check the status on pending referrals** and that is frustrating

# Open-ended Comments



## Time Availability

For patients **to receive the best possible care...there needs to be a complete team** with a provider, nurse, and CMA, so that **...a sufficient amount of time can be spent with the patient** to make them feel that they have been thoroughly taken care of.

## Provider and Staff Communication Around Diagnosis

The manager and providers are ALL approachable with questions or concerns...  
**I am not afraid to ask questions ...if I have a concern regarding a patient**

# Reliability and Construct Validity



- Acceptable internal consistency reliability (Cronbach's alpha  $\geq 0.70$ )
- Acceptable confirmatory factor analysis results
  - ▶ Factor loadings and goodness-of-fit indices
- Statistically significant correlations with:
  - ▶ Most of the SOPS Medical Office Survey composite measures
  - ▶ Most of the overall ratings of health care quality and patient safety

# Diagnostic Safety Pilot Results and Upcoming Data Submission



- 2020 pilot study results are on the SOPS Medical Office Survey web page
- Data submission for the SOPS Medical Office Survey Database opens **Sept 1 – Oct 20, 2021** and will accept:

SOPS Medical Office

Diagnostic Safety Supplemental Items

Value and Efficiency Supplemental Items

# Supplemental Item Survey Administration Instructions



- Add the items toward the end of the SOPS Medical Office Survey just before the Background Questions
- Administer the supplemental items without modification or deletions

# Additional Resources

## Surveys on Patient Safety Culture™ (SOPS®)



### 2021 Hospital Database Reports for HSOPS 1.0 & 2.0

New results available from the 2021 Hospital Database for the Hospital SOPS 1.0 and 2.0 Surveys.

### Upcoming SOPS Survey Data Submissions

Learn more about data submission for 2021, and watch a video.

### New Supplemental Items on Diagnostic Safety

Learn more about new supplemental items for the Medical Office Survey.

# Diagnostic Safety Data Entry and Analysis Tool



(April 2021)

**Diagnostic Safety Supplemental Items  
for the SOPS Medical Office Survey**

**1. Entering Data**

[Instructions](#)  
[Report Cover Sheet](#)  
[Data Entry](#)

**2. Your Medical Office  
Results**

[Composite Measure Results](#)  
[Item Results](#)

**3. Comparative Results**

[Composite Measure Results](#)  
[Item Results](#)

**4. Understanding/  
Sharing Your Results**

[Explanation of Calculations](#)  
[Interpreting Your Results](#)  
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# Diagnostic Safety Improvement Resources



## Surveys on Patient Safety Culture™

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

#### I. Purpose

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

#### II. How To Use This Resource List

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

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

#### IV. Resources by Composite Measure

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

##### **Composite 1. Time Availability**

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

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

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

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

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

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

# Action Planning Tool



## Action Planning Tool for the AHRQ Surveys on Patient Safety Culture



### Action Plan for the AHRQ Surveys on Patient Safety Culture

Facility Name:  
Date last updated:

Page 1

#### Defining Your Goals and Selecting Your Initiative

1	What areas do you want to focus on for improvement?	
2	What are your goals?	
3	What initiative will you implement?	
Notes or Comments		

# SOPS Bibliography



## Search All Bibliographies

Search

### Healthcare Setting

- Hospitals (268)
- Nursing Homes (17)
- Medical Offices (16)
- Community Pharmacies (8)
- Ambulatory Surgery Centers (1)

### Topics

- Analyses Linking Composite Measures with Site and/or Respondent Characteristics (73)

## SOPS Bibliography

Browse or search for publications about the development and use of SOPS surveys and other topics related to assessing patient safety culture.

### Results

1-50 of 310 Bibliography Items displayed

1 2 3 4 5 6 7 [next >](#) [last »](#)

Wijaya MI, Mohamad AR, Hafizurrachman M. Shift schedule realignment and patient safety culture. *Int J Health Care Qual Assur.* 2020; : 1-13.  
<https://www.ncbi.nlm.nih.gov/pubmed/32012498>

Lee SE, Dahinten VS. The enabling, enacting, and elaborating factors of safety culture associated with patient safety: A multilevel analysis. *Journal of Nursing Scholarship.* 2020 <https://pubmed.ncbi.nlm.nih.gov/32573867/>

Palmieri PA, Leyva-Moral JM, Camacho-Rodriguez DE, et al. Hospital Survey on Patient Safety Culture (HSOPSC): A multi-method approach for target-language instrument translation, adaptation, and validation to improve the equivalence of meaning for cross-cultural research. *BMC Nurs.* 2020, 19(23): 1-13. <https://pubmed.ncbi.nlm.nih.gov/32308560>

# SOPS Technical Assistance (TA)



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**Website:** [www.ahrq.gov/sops](http://www.ahrq.gov/sops)

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 Agency for Healthcare Research and Quality  
Advancing Excellence in Health Care



- Surveys on Patient Safety Culture** 
  - Hospital Survey 
  - Medical Office Survey 
  - Nursing Home Survey 
  - Ambulatory Surgery Center Survey 
  - Community Pharmacy Survey 

# QUESTIONS & ANSWERS

# How to Ask a Question

- Question and Answer
  - ▶ Select Q&A
  - ▶ Type question in the box that opens
  - ▶ Make sure “All Panelists” is selected



**THANK YOU!**

**PLEASE COMPLETE THE WEBCAST  
EVALUATION**