

# Pathways for Patient Safety™

Module Two:

## Assessing Where You Stand



### A Partnership:

Health Research & Educational Trust

Institute for Safe Medication Practices

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PATHWAYS FOR PATIENT SAFETY™

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# Overview

## Story:

**Assessing our practice helped us look objectively** at what we were doing wrong and what we were doing right. We found out that you always think you're better than what you are. We thought we were so advanced with our electronic medical records, but we revealed through the team-based assessment we undertook that we weren't doing the basic things right. We weren't communicating with patients and we weren't providing them with the proper handouts. Overall, we weren't providing patient education.

In the first Pathways for Patient Safety™ module, *Working as a Team*, you were introduced to information and tools to help you build a strong team in your physician practice. Module Two, *Assessing Where You Stand*, provides steps towards minimizing medical error in your practice through enabling effective assessment of what should be in place to support safe care. This module will show you how to:

- assess current patient safety practices and protocols,
- prioritize and plan to address issues revealed by the assessment, and
- understand factors that influence patient safety, such as safety culture and safety climate.

Module Two also provides your Patient Safety Team with a set of resources to improve patient safety.

- **Step One** features tools that will enable you to assess your current practices in order to find your strengths and weaknesses as they relate to providing safe care.
- **Step Two** outlines the elements of an effective practice culture and enables you to understand where your organization is before you put plans and changes into motion.
- **Step Three** describes the process that will enable you to plan and achieve improvements in patient safety. Examples of plans and goal documents outline a structure and suggest projects, staff responsibilities, and directions for higher achievement.
- **Step Four** outlines several specific process areas that may need improvement and shares tools for deeper practice assessment.

# Why Assessment, Culture, and Planning Matter

Routine and systematic assessment of patient safety practices is essential to assuring that the entire staff is doing everything they can to ensure a safe practice and avoid preventable harm to their patients and themselves. The Physician Practice Patient Safety Assessment (PPPSA)<sup>1</sup> was created to:

- heighten awareness of the distinguishing characteristics of a safe physician practice and
- create a new reference point and baseline for efforts to enhance and sustain patient safety.

This module will teach you how to use the PPPSA effectively to identify your practice's strengths and weaknesses.

Module Two also focuses on the importance of a “patient safety culture.” It defines the characteristics of practices with strong patient safety cultures and provides tips on how to achieve and sustain this within your own practice. Lastly, drawing on an excellent outline from the Joint Commission, this module discusses how to create a patient safety improvement plan.

# Steps to Success

Because patient safety encompasses a wide range of issues affecting many different aspects of a physician practice, it can be difficult to find a starting point for making changes. As a result—and despite believing that patient safety is important—many practices postpone (sometimes indefinitely) addressing this complex issue.

Practices that are successful in their commitment to patient safety improvements may employ two radically different approaches to change. Some practices—determined to make fast, dramatic transformations—tackle issues head-on with large initiatives and sweeping changes. Others work more slowly, addressing more obvious, less complex issues first and building toward larger changes. Although most practices follow the latter approach, no matter what your practice's style, improving patient safety requires that you be able to:

- assess current patient safety processes within your practice and
- measure progress—and success—as changes are made.

## Step One—Assess Your Practice

It is difficult to create a plan for improving your practice's patient safety processes if you do not know exactly where you stand now. The Physician Practice Patient Safety Assessment™ (PPPSA) is a tool that can help you evaluate your current safety practices and then measure your progress toward specific goals. The PPPSA was designed by the Health Research and Educational Trust, the Institute for Safe Medication Practice and the Medical Group Management Association Center for Research, with generous support from the Commonwealth Fund. It is available for download in PDF format at [www.physiciansafetytool.org](http://www.physiciansafetytool.org). The assessment is available free of charge if the practice provides some demographic information. An online comparison report also is available for a nominal fee. With the comparison report, your practice will receive access to a workbook that provides additional tools and resources for areas where your scores were weaker.

### How the PPPSA Works

The PPPSA was created to help your practice achieve its patient safety objectives. You can use the PPPSA to:

- gain specific ideas to improve patient safety;
- compare practice data to aggregate results for similar practices;



**It is difficult to create a plan for improving your practice's patient safety processes if you do not know exactly where you stand now.**

- enhance your team’s awareness of patient safety issues;
- heighten awareness of characteristics that make a practice safer;
- create a reference point and baseline to enhance and support patient safety;
- document successes and track progress; and
- prioritize results and define next steps in your patient safety improvement plan.

The PPPSA enables you to evaluate your practice’s level of implementation of best practices in six domains on a five-point scale ranging from “No Activity” to “Fully Implemented Everywhere.” The key areas are:

- **Medications:** There are a number of risks to patient safety related to various aspects of medication use. Because this is the area of patient safety most thoroughly studied, this section includes a large number of items.
- **Handoffs and transitions:** Patients often receive care from a number of different clinicians and facilities. Coordinating and tracking these clinical events is not simple or easy, and practices implement various manual and computerized systems to accomplish this task.
- **Surgery/anesthesia & sedation/invasive procedures:** Many physician practices perform surgery and invasive procedures that were once limited to hospitals. These activities entail a variety of risks, including those associated with sedation and anesthesia.

- **Personnel/qualifications:** Practitioners and practice staff receive sufficient orientation to elements of safe care and undergo continual education and evaluation of skills to ensure consistent and appropriate application of those skills.
- **Practice management/culture:** In addition to the specific actions related to particular aspects of patient care, such as medications or tracking diagnostic tests, there are also things the practice can do as a whole to support and complement the specific actions. Some of these help provide a culture of safety in the practice.
- **Patient education/communication:** Patients’ understanding of their illnesses and of recommendations for their care is particularly important in ambulatory care. This section includes actions that practices can take to help patients carry out the responsibility of following their care plans, including taking prescribed medications, and getting needed tests.

The PPPSA also includes 21 demographic questions and 79 assessment items. Time to complete can vary by practice, depending on the discussions that occur.

### How to Complete the PPPSA

Because of the complexities and nuances involved in providing safe care, the entire Patient Safety Team should be involved in completing the PPPSA. Including all members of your team will provide the range of perspectives essential to identifying existing and potential problems and designing successful, sustainable solutions. See Module One, *Working as a Team* for tips on creating your Patient Safety Team(s). Each team should include—but not necessarily be limited to—a medical director or physician, an administrator or office manager, a nursing supervisor or nurse clinician, and non-physician providers. It is also good to include laboratory supervisors, radiology/imaging supervisors, a pharmacist, a risk manager, and administrative support staff members.

### What to Do with What You Learn

PPPSA results highlight what a practice does well and where initial and longer-term improvement efforts need to be focused. The results should inform the development of a Patient Safety Plan and the goals that it outlines. They can be used as benchmarks in daily communication, guides for educational efforts, and agenda items during Patient Safety Meetings. (See Module One, *Working as a Team*, for more on Patient Safety Meetings.) Coupled with external safety-related publications and internal experiences, the evidence derived from the PPPSA will help drive the physician practice staff toward improvement.





## When you ask people to explain their thoughts on the culture of your practice... you should see a set of common themes and beliefs.

### Step Two—Create a Culture of Safety

*Safety culture* and *culture of safety* are frequently encountered terms referring to a commitment to safety that permeates all levels of an organization from frontline personnel to executive management. More specifically, *safety culture* calls up a number of features identified in studies of **high reliability organizations**—organizations outside of health care with exemplary safety performances.<sup>2,3</sup> These features include:

- acknowledgment of the high-risk, error-prone nature of an organization's activities,
- a blame-free environment where individuals are able to report errors or close calls without fear of reprimand or punishment,
- an expectation of collaboration across ranks to seek solutions to vulnerabilities, and
- a willingness on the part of the organization to direct resources for addressing safety concerns.<sup>4</sup>

The U.S. Veterans Affairs system has explicitly focused on achieving a culture of safety, in addition to its focus on a number of specific patient safety initiatives.<sup>5</sup> The impact of such efforts are very difficult to assess, but some tools

for quantifying the degree to which organizations differ with respect to safety culture have begun to emerge.<sup>6</sup>

When you ask people to explain their thoughts on the culture of your practice, you will probably not get the same responses from everyone, but you should see a set of common themes and beliefs. If responses vary widely in comparison, you may have a problem with your practice's cultural identity. For instance, does one group see your office as a place to provide services for the sick while another views it as a business that

#### ***Did You Know?***

*The culture of an office practice is conveyed in the office's:*

- *policies,*
- *customs,*
- *training,*
- *communication,*
- *physical environment,*
- *organizational structure,*
- *management behavior,*
- *goal measurement,*
- *rewards/recognitions, and*
- *ceremonies/events.*<sup>7</sup>

is there to make money? Although neither view is right or wrong, disagreement over core values can cause problems in every day business and when trying to implement change.

Culture encompasses everything a practice does, including how it treats its customers and colleagues, both internal and external. Culture also has been shown to have a strong correlation with financial success. “Medical groups that have better financial performance exhibit a culture that focuses on the patient and on providing high-quality services.”<sup>8</sup> The culture of a practice tells employees what is—and what is not—acceptable behavior in their daily activities. Finally, a practice’s culture dictates how patient safety is integrated into daily work. Is there freedom in the practice for employees at all levels who witnesses unsafe practice to speak up without fear of repercussion? Is the patient the number one priority in all activities of the practice?

### ***Did You Know?***

*In 2006, PPPSA respondents indicated that 55% of their practices had no protocols for providing emotional support to staff members or clinicians should an adverse event occur. This cultural assessment tool can help you learn more:*

**(See Attachment 2A, Medical Group Practice Culture Survey.)**

### **Importance of Practice Culture in Patient Safety**

It is unrealistic to expect that a practice can eliminate the occurrence of all errors. However, a practice can significantly reduce harm to patients due to human error and can minimize opportunities for errors by instilling reliable processes and high-performing teams (see Module One, *Working as a Team*, for tips on building your team). A practice can create a blame-free culture in which errors and near misses can be openly discussed so that the practice can learn from them, thereby continuing to improve processes that reduce the potential for future occurrences.

The PPPSA domain on “Practice Management/Culture” includes assessment questions that probe working relationships, communication behaviors, and learning exchanges within the practice.



**A practice can create a blame-free culture in which errors and near misses can be openly discussed so that the practice can learn...**

### Aspects of Practice Culture

Health care has emulated other high-risk industries to define basic, essential cultural concepts. The three elements of practice culture described below must be in place for your office to effectively support and sustain patient safety.

1. Leadership ensures that patient safety is listed as top priority in everything the organization does.
2. Rewards and recognition are used to reinforce safe behaviors.
3. Open communication exists. Employees at all levels are empowered to speak up when they witness unsafe practices.

Although safety culture starts with leadership, it cannot be sustained by leadership alone. Employees should be held accountable for their actions and decisions, and consequences should be determined early in the process.

### Blame-Free Culture

A blame-free culture makes safety a priority over assignment of blame. To facilitate learning and improvement, a blame-free culture supports transparency for discussing errors and near misses. A blame-free culture is built and nurtured through the teamwork and communications tactics outlined in Module One, *Working as a Team*. It encourages team members to achieve the open communication essential for improving patient safety.

Creating a blame-free culture is imperative for practices wishing to create an effective team environment. According to Manoj Pawar, MD,<sup>9</sup> success in three core competencies (outlined below) can help your staff members build support for a blame-free culture in

their daily work. When used by your Patient Safety Team to identify areas of current weakness, the questions and guidelines suggested by Dr. Pawar will help focus efforts aimed at creating and improving your practice's blame-free culture.

#### 1. Develop Process Focus

- When something goes wrong, instead of asking “Who did it?” do you ask “What part of the process allowed this to happen?”
- Instead of immediately asking yourself, “How can I protect myself?” do you ask, “How can I learn from this experience?”
- Instead of viewing yourself as external to the problem, do you consider what your role was in the process that created the problem?
- Do you operate from a place of fear or display courage in the pursuit of growth and learning?
- As a group, talk about focusing on processes, not people, and about cultivating a culture of curiosity and learning while resisting the impulse to self-defend.
- Leadership is necessary to maintaining a process-focused environment, and leaders must always remind and redirect individuals towards the process-focused approach.

## 2. Ensure Alignment of Purpose

- Do leadership and management ask staff members questions such as:
  - “What do you need in life?”
  - “What do you want in life?”
  - “What is really important to you?”
  - “What are you willing to take a stand for even if it is not popular?”
  - “What aggravates you?”
  - “What are the opposite of these things?”
  - “What are your short and long term goals, both professionally and personally?”
- Do they honestly use the answers to outline the group’s purpose to the team members?
- To foster alignment, are team members reliability given the opportunity to reflect upon how their values and goals relate to those of the group.

## 3. Foster Effective Communication

- Are team members encouraged to suspend any previous biased assumptions prior to discussing improvements and other potentially difficult issues?
- Is a balance created between advocacy, sharing of one’s own perspective and inquiry, and discovering the perspectives of others through a spirit of curiosity?
- Before adding their own perspectives, is everyone encouraged to try to understand everyone else’s ideas? This approach helps everyone feel like valued and respected parts of the solution.

## Patient-Centered Culture

A patient-centered culture places the welfare of the patient at the center of the decision-making and goal-setting processes. A practice with a patient-centered culture will be a safer practice—practices that embrace this philosophy are discovering benefits. As a review process for your practice Safety Team(s), the following could be used to measure your commitment to patient-centeredness.<sup>10</sup>

- **Selection:** Hire people with personalities and attitudes consistent with a high service orientation.
- **Training and socialization:** Provide existing employees supportive training that focuses on improving their knowledge about the practice and its services, active listening skills, and ability to show patience and appropriate emotions.
- **Structural design:** Look for ways to reduce unnecessary rules and regulations so that your staff can adjust its behavior to the needs of patients.
- **Empowerment:** Create latitude in employees’ positions so they have the discretion to make some day-to-day decisions about job-related activities.
- **Leadership:** Effective leaders in customer-responsive cultures communicate a customer-focused vision and demonstrate customer-receptive behaviors.
- **Performance evaluation:** Use behavior-based performance evaluations to improve customer service.
- **Reward systems:** Reward good service by recognizing extraordinary efforts to please patients. Make compensation and promotions contingent on outstanding customer service.

### Measuring Your Practice's Culture

Once your team understands the elements of a safety culture, undertaking an in-depth analysis of your practice culture will enlighten your discussions and provide direction for the creation of a culture of safety in your office. The survey instrument we suggest using is the Medical Group Practice Culture Survey, which was developed at the University of Minnesota<sup>11</sup> specifically for use in the physician practice arena. It will help you determine the characteristics of the organizational culture in your practice and will allow your team to measure the degree of agreement among staff about what encompasses your practice's culture. (See Attachment 2A, [Medical Group Practice Culture Survey](#).)

The survey consists of 18 statements focused on the core themes of practice culture and prompts staff members to evaluate their practice culture on a 5-point scale. After the survey is filled out anonymously by each staff member, data is collected, analyzed, and discussed by the team. Because views on culture can vary depending on where a person works, you may also wish to collect data on the participant's job designation. However, to maintain anonymity and attendant freedom of expression, keep job designations as generic as possible.

### Changing Your Culture

Because a practice's less-than-optimum cultural characteristics are sometimes long-standing, change can be difficult and may take years to accomplish. Having evidence from the PPPSA assessment and using comparable data from other practices can help create a sense of urgency to drive necessary change. Listed below are a few more tips to help you in the process.

#### **Tip 1. Define the future culture you**

**desire:** Mapping out a vision for the future culture of the practice will help give you a clear path to make the necessary changes. This should be reflected in the mission and the Patient Safety Plan for the practice. (Step Three in this section will show you how to create a Patient Safety Plan.)

**Tip 2. Leadership has to lead:** Without the support of top leadership, change efforts are likely to fail.

**Tip 3. Get buy-in from staff:** Getting the staff involved early in the process can help create buy-in. Even if your staff does not completely agree with the changes that are suggested, participating in the process gives them ownership and can help make the transition easier. As with most dramatic changes, you have to start with leadership.

**Tip 4. Make changes:** Set a clear timetable that lets everyone know when changes are effective. Outline and document timeframes, periodically reviewing your plan and goals at team meetings to underscore their importance.



**...change can be difficult and may take years to accomplish.**

**Tip 5. Reinforce the changes:** Once changes occur, continue to nurture the process. It takes a long time for a new vision to set in. Positive reinforcement is essential.

**Tip 6. Hire accordingly:** Ensure that your hiring process includes your new values so that you hire people who believe in what you are trying to accomplish.

**Tip 7. Measure improvement:** Continue to measure your level of implementation and make adjustments and add additional reinforcements as necessary. Tools introduced in Step Four will introduce some effective methods for documenting change.

### **Tools You Can Use**

Patient Satisfaction surveys are important tools to collect data to inform practice improvement efforts. Be sure to incorporate safety questions in your survey processes.

### Step Three—Prioritize and Plan

A Patient Safety Plan will help your practice implement and sustain safety improvements. A good plan will enable you to structure your work as effectively as possible. Your plan should be reviewed yearly in conjunction with your practice's annual assessment. Revise the plan as needed based on the assessment results.

How you create your patient safety improvement plan depends largely on the changes that need to be made and the culture existing within your practice. Your Patient Safety Team is responsible for:

- identifying opportunities for improvement;
- achieving measurable, positive change;
- sustaining areas of strength;
- reaching identified goals; and
- continually reassessing your patient safety practices to identify new opportunities for improvement.

Each of these aims should be detailed in an annual Patient Safety Plan. The Joint Commission has created an excellent sample outline of a Patient Safety Plan. It is available at [http://www.jointcommission.org/PatientSafety/pt\\_safety\\_plan.htm](http://www.jointcommission.org/PatientSafety/pt_safety_plan.htm) and is reprinted here with permission. As you look over the sample outline, please note the TIPS to help your Patient Safety Team as you create your own plan.



**How you create your patient safety improvement plan depends largely on the changes that need to be made and the culture existing within your practice.**



## SAMPLE OUTLINE FOR A PATIENT SAFETY PLAN

### **Program Goals (consistent with organization mission)**

#### **Scope of the Program**

- Activities & functions relating to patient safety (*TIP: Look at Step Four— Dig Deeper for ideas on program components.*)
- Participating sites, settings, and services

#### **Structure**

- Management of the Program (*TIP: Regardless of the size of the practice, be sure to Designate a Patient Safety Officer.*)
- Components (safety-related offices, committees, functions)
- Interdisciplinary participation (*TIP: In larger practices, include representatives of all clinical and administrative disciplines in the practice. For smaller practices, include everyone. In all cases, include every member of the staff in various patient safety activities. Remember: Safety is a team sport!*)
- Oversight

#### **Mechanisms for coordination**

- Among components of the Program
- Among the professional disciplines
- Across the organization

#### **Communicating with patients about safety**

- Patient education
- Informing patients about their care

#### **Staff education**

- Safety-related orientation & training (*TIP: Establish a training agenda each year and stick to it; update topic areas based on patient safety leaders' monthly newsletters and other sources of patient safety news and innovations.*)
- Team training
- Expectations for reporting (*TIP: Establish monthly tracking of key patient safety statistics and post in a public space.*)

#### **Safety improvement activities**

- Definition of terms
- Prioritization of improvement activities
- Routine safety-related data collection and analysis
  - Incident reporting
  - Medication error reporting
  - Infection surveillance
  - Facility safety surveillance
  - Staff perceptions of, and suggestions for improving patient safety
  - Staff willingness to report errors
  - Patient/family perceptions of, and suggestions for improving patient safety



- Identification, reporting, and management of sentinel events
- Proactive risk reduction
  - o Identification of high-risk processes
  - o Failure mode, effects, and criticality analysis
- Reporting of results
  - o To the Patient Safety Program
  - o To organization staff
  - o To executive leadership and the governing body

## Step Four—Dig Deeper: Several Specialized Assessment Tools

This section introduces some specific tools that target distinct areas that you may be interested in exploring. The general results from the PPPSA can help identify which of these tools might be most appropriate for immediate use and which others could be used as your practice evolves and behaviors change with fluctuating staff and patient load.

### Specialized Tool 1: Team Performance Observation Tool

Module One, *Working as a Team* emphasized the importance of building teamwork mentality and clear communication processes into your practice. The **Team Performance Observation Tool (PDF)** reinforces the concepts highlighted in the TeamSTEPPS program, described in *Working as a Team* by documenting the behaviors that your team members should observe in each of the five

key performance areas for patient safety. This flexible tool can be used for the following purposes:

- Review of improvement areas at a staff meeting. (Discuss resulting items in general terms rather than highlighting individual situations or staff deficiencies.)
- Individual coaching. (Take appropriate care to assist staff members in reaching individual improvement goals in a blame-free process.)
- Defining stretch goals or initial goals for a clinic or your unit.
- Brainstorming and prioritizing improvement opportunities for safer care.

### ***Did You Know?***

The Joint Commission defines a sentinel event as:

*“...an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase, “or the risk thereof” includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. Such events are called sentinel because they signal the need for immediate investigation and response.”<sup>12</sup>*

### Specialized Tool 2: Root Cause Analysis and Action Plan

**The Framework for Root Cause Analysis (RCA) and Action Plan**, created by the Joint Commission, is designed for use after a sentinel event has occurred, but can also be used after a near miss. Its purpose is to determine what happened, why it happened, and what actions can be taken to make sure it doesn't happen again. The product of this tool is an action plan that details strategies that will be implemented to prevent future occurrences. It also presents the measures that will be used to determine the effectiveness of those strategies.

Participation in the RCA should be completed by all employees (at every level) that were involved with the event. The primary focus of the RCA should be systems and processes rather than individual performance. The goal is:

- identification of risk points in clinical and/or organizational processes and their contributions to the event; and
- determination of potential improvements in processes or systems to decrease the likelihood of such events in the future, or a determination that no such improvement opportunity exists.

The final product of the RCA is a plan of action that takes into account each root cause that was identified. This plan should complement a practice's existing general patient safety plan and support those activities appropriately.

### Specialized Tool 3: Health Literacy Assessment Tool

Health literacy is a key element in the safety of care and a patient's ability to interact with their clinicians as partners. However, a 2008 Commonwealth Fund report indicated that 86% of practices never/rarely formally assess their patient's health literacy levels.<sup>13</sup> PPPSA assessment respondents indicated that only 25% have a staff that is fully trained to recognize and respond to health literacy concerns. Module One, *Working as a Team*, provided tools to help staff members communicate clearly with patients on an individual basis. However, there is also a need to more broadly assess your practice's patient base for potential literacy issues.



**The primary focus of the RCA should be systems and processes rather than individual performance.**

The American Medical Association Foundation has taken the lead in providing practitioners with several tool kits and primers to help increase awareness of patient health literacy issues. Click on this link to learn more:

[American Foundation Health Literacy Video.](#)

To help you systematically identify and address health literacy issues in your practice, PPPSA created a *Health Literacy Assessment Tool*, which was developed from materials available from the American Medical Association.<sup>14</sup> The tool’s two lists (shown below) can be used as a first step in determining who in your patient population may have limited literacy. Staff members should become familiar with these characteristics to develop a shared mental model on how to discuss and identify patients that may have special needs. These lists should also be distributed to new staff members to help them develop the skill to recognize the problem and illustrate the practice’s commitment to communicating clearly to patients in support of patient-centered, safe care.

**1. Key Risk Factors for Limited Literacy**

- Elderly
- Low income
- Unemployed
- Did not finish high school
- Minority ethnic group (Hispanic, African American)
- Recent immigrant to United States who does not speak English
- Born in United States but English is second language

**2. Behaviors and Responses that May Indicate Limited Literacy**

***Behaviors***

- Patient registration forms are incomplete or inaccurately completed
- Frequently missed appointments
- Non-compliance with medication regimens
- Lack of follow-through with laboratory tests, imaging tests, or referrals to consultants
- Patients say they are taking their medication, but laboratory tests or physiological parameters do not change in the expected fashion

***Responses to receiving written information***

- “I forgot my glasses. I’ll read this when I get home.”
- “I forgot my glasses. Can you read this to me?”
- “Let me bring this home so I can discuss it with my children.”

***Responses to questions about medication regimens***

- Unable to name medications
- Unable to explain what medications are for
- Unable to explain timing of medication administration<sup>14</sup>



## A medical practice that is assessing how it manages laboratory testing may want to confirm the clinicians' and staffs' subjective assessment of the relevant processes...

### Specialized Tool 4: Tracking Audit for Medication Safety: Office Visits

A medical practice that is assessing how it manages medications may want to confirm the clinicians' and staffs' subjective assessment of the relevant processes (for example, those referred to in PPPSA items 29.1, 29.3, and 34.1). One way to do this is to “audit” what happens with medications for a limited number (approx. 30) of patients. **The Tracking Audit for Medication Safety** tool demonstrates what information is tracked in such an audit. (See Attachment 2B, **Tracking Audit for Medication Safety: Office Visits**.)

To perform an audit:

- First, decide what aspects of medication management you wish to track and audit.
- Then, decide which patients to track, such as all patients seen by the practice on one particular day. (The audit can be done in real time or in retrospect, if the required information can be obtained retrospectively.)

- Determine which Patient Safety Team member(s) will track these patients' experiences and record the needed data. (You may want to “try out” your tool to see if it works and whether the data you are trying to collect is available only in real time rather than retrospectively.)
- Once the data are collected, analyze it to understand what it reveals about these aspects of medication management. You may find that the results do not match perfectly with what your clinicians and staff think is being done.
- For more information on medication safety, see Module Three, *Creating Medication Safety*.

### Specialized Tool 5: Laboratory Test Management Audit Tool

A medical practice that is assessing how it manages laboratory testing may want to confirm the clinicians' and staffs' subjective assessment of the relevant processes (for example, those referred to in PPPSA items 30.2 and 30.7). One way to do this is to “audit” what happens with lab tests for a limited number (approx. 30) of patients. **The Laboratory Test Management Audit Tool** demonstrates what information is tracked in such an audit. (See Attachment 2C, **Lab Test Audit**.)

To perform such an audit:

- First, decide what aspects of laboratory testing you wish to track and audit.
- Then, decide which patients to track, such as all patients seen by the practice on one particular Thursday morning. (The audit can be done in real time or in retrospect, if the required information can be obtained retrospectively.)
- Determine which team member(s) will track the patients' experiences and record the needed data. (You may want to “try out” your tool to see if it works and whether the data you are trying to collect is available only in real time rather than retrospectively.)
- Once the data are collected, analyze it to understand what it reveals about these aspects of laboratory testing. You may find that the results do not match perfectly with what your clinicians and staff think is being done.

### Accrediting Organization Resources

This module has introduced some specialized tools aimed at improving your organization internally, but practices should also consider the role of accrediting organizations as partners for improvement. Accreditation requirements and standards can guide the physician practice's development of a patient safety program. For instance, your practice may choose to become accredited by the Joint Commission or the Accreditation for Ambulatory Health Care. The assessment tools offered by these organizations will also aid your practice in its patient safety improvement process. These links will provide you with more information on such organizations and programs: [Joint Commission Accreditation Standards](#) and [Accreditation for Ambulatory Health Care](#).

## Summary of Key Points

Building on its team development and communications work from Module One, *Working as a Team*, your team has learned skills to conduct a general examination of your safety practices. Based on the assessment process you have learned, you can structure your safety improvement work by developing a plan focused on a set of patient safety goals. A set of specialized tools enables you to focus on improving some key elements of your practice's care continuum.

## Attachments

- 2A. MEDICAL GROUP PRACTICE CULTURE SURVEY
- 2B. TRACKING AUDIT FOR MEDICATION SAFETY: OFFICE VISITS
- 2C. LABORATORY TEST MANAGEMENT AUDIT TOOL



## 2A. MEDICAL GROUP PRACTICE CULTURE SURVEY

The purpose of this survey is to determine the characteristics of the organizational culture in your group practice. There are no right answers. Simply provide your personal judgment about what is valued by the group and how things are done. Please provide your judgments about each statement by circling the appropriate number. To what degree do the following statements reflect the conditions in your group practice?

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<b>In our group practice:</b>	<b>Not at all</b>			<b>To a great extent</b>
1. There is a great deal of sharing of clinical information.	1	2	3	4
2. Our administrative decision making process can be best described as top down when compared to bottom up consensus building.	1	2	3	4
3. We are a data driven practice.	1	2	3	4
4. We can count on being treated fairly.	1	2	3	4
5. We easily adapt to changes in the field.	1	2	3	4
6. We value information technology.	1	2	3	4
7. There is a close collegial relationship among the care team.	1	2	3	4
8. There is an emphasis on physician individuality; each physician has the right to practice according to his/her own style.	1	2	3	4
9. We are quick to adopt new techniques and practices.	1	2	3	4
10. We encourage internal discussion of patient care adverse events.	1	2	3	4

<b>In our group practice:</b>	<b>Not at all</b>			<b>To a great extent</b>
11. Our administrators are considered to be a very important part of our patient care team.	1	2	3	4
12. We view ourselves more as a business than as a community health center.	1	2	3	4
13. A strong sense of belonging to the group.	1	2	3	4
14. There is a high degree of organizational trust.	1	2	3	4
15. Bottom line considerations influence most of our decisions regarding what services to offer and how to provide them.	1	2	3	4
16. There is an identifiable practice style that we all try to adhere to.	1	2	3	4
17. There is a feeling that we are autonomous clinicians, but practicing in the same organization for support services.	1	2	3	4
18. There is an open discussion of clinical failures.	1	2	3	4

**2B. TRACKING AUDIT FOR MEDICATION SAFETY: OFFICE VISITS**

A medical practice may want to document how it manages medication safety during office visits. One way to do this is to perform an “audit” of what happens during office visits for a limited number of patients (approximately 30 is optimum). This tool is an example of what information to track when conducting such an audit. You might first pilot the audit tool for a short period of time – for instance, information about medications during office visits for just one day – to get an initial “feel” for how the audit tool works.

Patient’s name and date of visit:	Name:  Date:	Name:  Date:	Name:  Date:	Name:  Date:
Were all of the patient’s medications solicited and recorded in the medical record?				
Was the patient provided with a complete list of medications during the encounter?				
Did someone determine whether the patient would encounter financial or other barriers to obtaining and taking the medication(s) prescribed?				
Comments				

## 2C. LABORATORY TEST MANAGEMENT AUDIT TOOL

This tool can be used by a medical practice to document how it manages laboratory testing. One way to do this is to perform an “audit” of what happens with lab tests for a limited number of patients (approximately 30 is optimum). This tool is an example of what information to track when conducting such an audit. You might first pilot the audit tool for a short period of time – for instance, information about laboratory testing during just one day – to get an initial “feel” for how the audit tool works.

Patient’s name and date of visit	Name:  Date:	Name:  Date:	Name:  Date:	Name:  Date:
Lab where test was sent and date sent	Lab  Date:	Lab  Date:	Lab  Date:	Lab  Date:
Dates results received from lab				
Patient or caregiver to whom results were given and date				
Comments				

# Additional Resources

## Suggested additional resources

In addition to the tools mentioned throughout this module and the references below, the author team suggests the following additional materials that may be of help in designing your own office staff programs to assess your practice generally for its safety behaviors and instill a culture of safety to support additional target assessment of key safety processes.

### Step 1 – Assess Your Practice

Book:

Boud, D. 1995. *Enhancing Learning Through Self-Assessment*. Routledge.

### Step 2 – Create a Culture of Safety

Article:

Modak, I., and J.B. Sexton, T.R. Lux et al. 2007. “Measuring Safety Culture in the Ambulatory Setting: The Safety Attitudes Questionnaire-Ambulatory Version.” *Journal of General Internal Medicine* 22: 1-45.

<http://www.pubmedcentral.nih.gov/picrender.fcgi?artid=2227589&blobtype=pdf>

Survey instrument and information:

Sexton, J.B., R.L. Helmreich, T.B. Neilands, K. Rowan, K. Vella, J. Boyden, P.R. Roberts, and E.J. Thomas. 2006. “The Safety Attitudes Questionnaire: Psychometric Properties, Benchmarking Data, and Emerging Research.” *BMC Health Services Research* 6:44.

Ambulatory version:

[http://www.uth.tmc.edu/schools/med/imed/patient\\_safety/Ambulatory%20SAQ.pdf](http://www.uth.tmc.edu/schools/med/imed/patient_safety/Ambulatory%20SAQ.pdf)

Survey use information:

[http://www.uth.tmc.edu/schools/med/imed/patient\\_safety/survey&tools.htm](http://www.uth.tmc.edu/schools/med/imed/patient_safety/survey&tools.htm)

Related article: <http://www.biomedcentral.com/1472-6963/6/44/abstract>

Toolkit:

Institute for Healthcare Improvement. “Develop a Culture of Safety.”

<http://www.ihl.org/IHI/Topics/PatientSafety/SafetyGeneral/Changes/Develop+a+Culture+of+Safety.htm>

Report:

“HRC Risk Analysis Supplement A. Risk and Quality Management Strategies 21: Culture of Safety.” 2005. ECRI Institute.

[http://www.ecri.org/Documents/Patient\\_Safety\\_Center/HRC\\_CultureofSafety.pdf](http://www.ecri.org/Documents/Patient_Safety_Center/HRC_CultureofSafety.pdf)

Report:

Marx, D. "Patient Safety and the Just Culture: A Primer for Health Care Executives." 2001. Trustees of Columbia University in the City of New York, Columbia University.

<http://psnet.abrq.gov/resource.aspx?resourceID=1582>

### **Step 3 – Prioritize and Plan**

Tool:

Joint Commission. "Sample Outline for a Patient Safety Plan."

[www.jointcommission.org/PatientSafety/pt\\_safety\\_plan.htm](http://www.jointcommission.org/PatientSafety/pt_safety_plan.htm).

Book:

"What Works: Effective Practices for Office-Based Care." 2006. Boston: CRICO/RMF.

<http://www.rmhf.harvard.edu/patient-safety-strategies/office-practices/main/index2.aspx?id>

<http://www.rmhf.harvard.edu/files/documents/What-Works-2006-ed.pdf> (pdf)

### **Step 4 – Digging Deeper / Several Specialized Assessment Tools**

CE/CME material:

"Assessing Health Literacy in Clinical Practice." 2007. Medscape.com.

<http://www.medscape.com/viewprogram/8203>

Report:

Weiss, B. "Health Literacy and Patient Safety: Help Patients Understand, 2nd Ed." 2007.

Chicago: American Medical Association. May 2007

<http://www.ama-assn.org/ama1/pub/upload/mm/367/healthlitclinicians.pdf>

Tool:

Massachusetts Coalition for the Prevention of Medical Errors. "Test Tracking Log Sheet."

<http://www.macoalition.org/Initiatives/docs/AmbulatoryTestTrackingLog.doc>

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## References

- 1 The Physician Practice Patient Safety Assessment. Medical Group Management Association Center for Research, Health Research and Educational Trust, Institute for Safe Medication Practices. 2005.
2. Roberts KH. Managing high reliability organizations. *Calif Manage Rev.* 1990;32:101-113.
3. Weick KE. Organizational culture as a source of high reliability. *Calif Manage Rev.* 1987;29: 112-127.
4. Pizzi L, Goldfarb N, Nash D. Promoting a culture of safety. In: Shojania KG, Duncan BW, McDonald KM, Wachter RM, eds. *Making Health Care Safer: A Critical Analysis of Patient Safety Practices. Evidence Report/Technology Assessment No. 43 from the Agency for Healthcare Research and Quality: AHRQ Publication No. 01-E058; 2001.*  
[ Available at: <http://www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat1.section.61719> ]
5. Weeks WB, Bagian JP. Developing a culture of safety in the Veterans Health Administration. *Eff Clin Pract* 2000;3:270-276.
6. Singer SJ, Gaba DM, Geppert JJ, Sinaiko AD, Howard SK, Park KC. The culture of safety: results of an organization-wide survey in 15 California hospitals. *Qual Saf Health Care.* 2003;12:112-118.
7. Vuletich M. Group culture: it's difficult to define. *MGMA e-Connexion.* April 2005
8. Gans DN. On the edge: examining industry trends - better-performing medical groups - how do they do it? *MGMA Connexion.* February 2006;6:NA.
9. Pawar, M. 2007. "Checklist for Assessing a Blame-Free Culture: Getting Beyond Blame in Your Practice." *Family Practice Management* 14(5):30-34.  
<http://www.aafp.org/fpm/20070500/30gett.html>
10. Adapted from: Pope C. Extreme make-over: Group practice edition – Seven steps to a patient-centered culture. *MGMA Connexion.* April 2005;5:4.

11. “Development of the survey included in this module began in 1996 by John Kralewski of the University of Minnesota and has been refined to include questions believed to get at the essential elements in defining practice culture. Development of the survey was based on a framework developed by Paul Reynolds, PhD, an organizational psychologist at the University of Minnesota. The instrument was further refined for use in medical practices through a process of interviewing physicians who also served as medical directors in their organizations.”
12. The Joint Commission. Sentinel Event glossary of Terms.  
[ Available at [www.jointcommission.org/SentinelEvents/](http://www.jointcommission.org/SentinelEvents/) ]
13. Barrett SE, Puryear JS, Westpheling K. Health Literacy Practices in Primary Care Settings: Examples from the Field. New York, NY: The Commonwealth Fund; January 2008
14. Adapted from: Weiss B. Health Literacy and Patient Safety: Help Patients Understand 2nd Ed. Chicago: American Medical Association. May 2007



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#### **About ISMP**

The Institute for Safe Medication Practices is a nonprofit organization recognized worldwide as the premier education resource for understanding and preventing medication errors. ISMP represents more than 30 years of experience in helping keep patients safe, and continues to lead efforts to improve the medication use process. Working with health care practitioners and institutions, regulatory and accrediting agencies, consumers, professional organizations, the pharmaceutical industry, and others, ISMP also provides timely, accurate medication safety information to the healthcare community, policy makers, and the general public. For more information on ISMP, or to read more about its other self-assessment tools for hospitals and community pharmacies, visit the Institute's web site at [www.ismp.org](http://www.ismp.org).

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MGMA is the premier membership association for professional administrators and leaders of medical group practices. Since 1926, MGMA has delivered networking, professional education and resources, and political advocacy for medical practice management. Today, MGMA's 21,500 members lead 13,500 organizations nationwide in which some 270,000 physicians provide as much as 40 percent of the health care services delivered in the United States. MGMA's mission is to continually improve the performance of medical group practice professionals and the organizations they represent. MGMA promotes the group practice model as the optimal framework for health care delivery, assisting group practices in providing efficient, safe, patient-focused and affordable care. MGMA is headquartered in Englewood, Colo., and maintains a government affairs office in Washington, D.C.