Attachment N - Omnibus Safety and Culture Survey - Medical Offices

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Form Approved
OMB No. 0935 -XXXX
Exp. Date XX/XX/20XX

OMNIBUS SURVEY OF DIAGNOSTIC SAFETY CULTURE: MEDICAL OFFICES

[Insert site name] and the RAND Corporation are collaborating to improve diagnostic excellence during patient care. *You are being asked to answer this survey because of your important role in patient care.*

This survey asks about aspects of your office's culture, including use of diagnostic safety event data, activities to improve the quality of care, and work environment. It should take no longer than 20 minutes to complete.

We are interested in learning about what it is like to work in your office. This survey asks for your opinions about patient safety issues, medical error, diagnostic error and event reporting in your office.

- **Patient safety** is defined as the avoidance and prevention of patient injuries or adverse events resulting from the processes of healthcare delivery
- A **patient safety event** is defined as any type of healthcare-related error, mistake, or incident regardless of whether or not it results in patient harm
- A **diagnostic safety event** is defined as an event where one or both of the following occurred, whether or not the patient was harmed:
    - Delayed, wrong or missed diagnosis: There were one or more missed opportunities to pursue or identify an accurate and timely diagnosis (or other explanation) of the patient's health problem(s) based on the information that existed at the time.
    - Diagnosis not communicated to patient: An accurate diagnosis (or other explanation) of the patient's health problem(s) was available, but it was not communicated to the patient (includes patient's representative or family as applicable).

RAND will combine your survey answers with the answers from others who complete the survey to produce only summary results. When presenting survey results, RAND will not include your name or any other information that could identify you.

If you have questions about this research or how to answer any of the questions, please contact Dr. Denise D. Quigley, at RAND at quigley@rand.org.

This survey is authorized under 42 U.S.C. 299a. This information collection is voluntary and the confidentiality of your responses to this survey is protected by Sections 944(c) and 308(d) of the Public Health Service Act [42 U.S.C. 299c-3(c) and 42 U.S.C. 242m(d)]. Information that could identify you will not be disclosed unless you have consented to that disclosure. Public reporting burden for this collection of information is estimated to average 20 minutes per response, the estimated time required to complete the survey. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The data you provide will help AHRQ's mission to produce evidence to make health care safer, higher quality, more accessible, equitable, and affordable. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: AHRQ Reports Clearance Officer Attention: PRA, Paperwork Reduction Project (0935-xxxx) AHRQ, 5600 Fishers Lane, Room #07W42, Rockville, MD 20857, or by email to the AHRQ MEPS Project Director at MEPSPROJECTDIRECTOR@ahrq.hhs.gov.

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YOUR MEDICAL OFFICE AND YOUR CURRENT POSITION

FILL IN YOUR MEDICAL OFFICE NAME:______________________________

1. **What is your position in the Office? (Please select one answer):**

   Providers
   - ☐ Physician (MD or DO)
   - ☐ Physician Assistant, Nurse Practitioner, Clinical Nurse Specialist, Nurse Midwife, Advanced Practice Nurse, etc.
   - ☐ Patient Care Aide
   - ☐ Registered Nurse (RN)

   Nursing
   - ☐ Registered Nurse (RN)
   - ☐ Licensed Vocational Nurse (LVN), Licensed Practical Nurse (LPN)

   Other clinical staff or clinical support staff
   - ☐ Medical assistant
   - ☐ Nursing Aide, Technician, Therapist, Other clinical staff or clinical support staff

   Management
   - ☐ Practice Manager, Office Manager, Office Administrator, Business Manager
   - ☐ Nurse Manager, Lab Manager
   - ☐ Other Manager

   Administrative or clerical staff
   - ☐ Front Desk, Receptionist, Scheduler (appointments, surgery, etc)
   - ☐ Referral staff
   - ☐ Insurance Processor, Billing staff, Medical Records
   - ☐ Other administrative or clerical staff position

   Other Role
   - ☐ Other Role

2. **Some offices have <u>an improvement team that includes a focus on diagnostic safety events</u>.** This means that your office has identified and recruited individuals at your office that are knowledgeable about any effort or intervention to reduce or prevent **<u>diagnostic errors</u>** (e.g., risk managers, quality directors, clinicians from the ED, radiology, lab, ICUs, nurses, pharmacists, members of your office's patient and family advisory council (PFAC), board members, and others).

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Does your office have an improvement team that includes a focus on diagnostic safety events?

- ☐ No
- ☐ Yes

3. **Are you part of the improvement team that includes a focus on diagnostic safety events?**
   - ☐ No
   - ☐ Yes, as a member
   - ☐ Yes, as a team leader

4. **How many years have you worked in this office in your current role?**
   [dropdown of years <6 months, 7-12 months, 1, 2, etc. through 70+]

5. **How many years have you worked in this office?**
   [dropdown of years <6 months, 7-12 months, 1, 2, etc. through 70+]

YOUR PERSPECTIVE ON PRIORITIES WITHIN YOUR MEDICAL OFFICE

We are interested in your perspective about the priorities at **your office**. When answering these questions, please consider all offices across your office in your answers.

(6) Within ***your office***, how important is patient safety compared to other goals?

Other Goals	Patient safety is less important	Patient safety is of the same importance	Patient safety is more important
a. Patient experience	O	O	O
b. Clinical quality of care	O	O	O
c. Financial performance of the office	O	O	O

IMPROVING PATIENT SAFETY

(7) In the last 6 months, did ***your office*** work to implement any of the following practices as it relates to reducing errors in diagnosis (including delayed, wrong, or missed diagnoses, and diagnoses not communicated to the patient)?

	Not Implemented		**Partially implemented**		**Fully Implemented**
a. Health care organization leadership builds a “board-to-bedside” accountability framework that includes structure, capacity, transparency, time, and resources to measure and improve diagnostic safety.	O	O	O	O	O
b. Health care organization promotes a just culture and creates a psychologically safe environment that encourages clinicians and staff to share opportunities to improve diagnostic safety without fear of retribution	O	O	O	O	O
c. Health care organization creates feedback loops to increase information flow about patients’ diagnostic and treatment-related outcomes. These loops, which include clinicians and external organizations, establish mechanisms for capturing, measuring, and providing feedback to the diagnostic team about patients’ subsequent diagnoses and clinical outcomes.	O	O	O	O	O
d. Health care organization includes multidisciplinary perspectives to understand and address contributory factors in analysis of diagnostic safety events. These perspectives include human factors, informatics, IT system design, and cognitive elements.	O	O	O	O	O
e. Health care organization actively seeks patient and family feedback to identify and understand diagnostic safety concerns and addresses concerns by codesigning solutions.	O	O	O	O	O

Question 7 Continued

In the last 6 months, did ***your office*** work to implement any of the following practices as it relates to reducing errors in diagnosis (including delayed, wrong, or missed diagnoses, and diagnoses not communicated to the patient)?

	Not Implemented		Partially implemented		Fully Implemented
f. Health care organization encourages patients to review their health records and has mechanisms in place to help patients understand, interpret, and/or act on diagnostic information.	O	O	O	O	O
g. Health care organization prioritizes equity in diagnostic safety efforts by segmenting data to understand root causes and implementing strategies to address and narrow equity gaps.	O	O	O	O	O
h. Health care organization has in place standardized systems and processes to encourage direct, collaborative interactions between treating clinical teams and diagnostic specialties (e.g., laboratory, pathology, radiology) in cases that pose diagnostic challenges.	O	O	O	O	O
i. Health care organization has in place standardized systems and processes to ensure reliable communication of diagnostic information between care providers and with patients and families during handoffs and transitions throughout the diagnostic journey	O	O	O	O	O
j. Health care organization has in place standardized systems and processes to close the loop on communication and follow up on abnormal test results and referrals.	O	O	O	O	O
k. Training clinicians and others involved in the diagnostic process to use evidence-based tools and strategies to collect complete and accurate personal health information from patients and family to facilitate timely and accurate diagnosis.	O	O	O	O	O
l. Ensuring that the office EHR captures the correct diagnosis by having a process in place to review, update and correct inaccurate diagnoses on "problem lists" and elsewhere in the EHR.	O	O	O	O	O
m. Providing patients and families whose preferred language for medical information differs from their care team with professional medical interpreters (on-site, video, phone) to assist with obtaining health information.	O	O	O	O	O
n. Integrating knowledge resources into the clinical workflow to help clinicians improve their diagnosis in real-time for cases where there is diagnostic uncertainty and educates and incentivizes (e.g., through a performance evaluation) clinicians to use these resources.	O	O	O	O	O
o. Training clinicians to optimize clinical reasoning in the diagnostic process.	O	O	O	O	O

Question 7 Continued

In the last 6 months, did ***your office*** work to implement any of the following practices as it relates to reducing errors in diagnosis (including delayed, wrong, or missed diagnoses, and diagnoses not communicated to the patient)?

	Not Implemented		Partially implemented		Fully Implemented
p. Implementing policy that outlines the protocol(s) care team members should take when handing off patients with diagnostic uncertainty to the care team assuming responsibility for the next phase of care, including different offices within the same office (e.g., office to skilled nursing facility, general office to free-standing pediatric office, office to primary care physician, to and from intensive care offices, between specialty services, etc.).	O	O	O	O	O
q. Ensuring patients with an uncertain diagnosis or where potential diagnoses involve high-risk conditions have a visit summary and explicit condition-specific instructions.	O	O	O	O	O
r. Improving process and protocol in place to ensure that patients when leaving the office have a list of lab and imaging test results and a list of any pending test results in the patient's preferred language for medical decision-making and written instructions on how to obtain those results.	O	O	O	O	O
s. Implementing a policy that outlines the responsibilities of each care team member to ensure all critical and subcritical test results are viewed by the appropriate care team and communicated to the patient in an appropriate timeframe based on the result.	O	O	O	O	O

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YOUR PERSPECTIVE ON MEASUREMENT STRATEGIES

(8) Based on your experiences in the last 6 months, how much do you disagree or agree with the following statements about **your office's measurement strategies on diagnostic safety events**?

	Strongly Disagree	Somewhat Disagree	Neither Agree nor Disagree	Somewhat Agree	Strongly Agree
a. I am familiar with the measurement of diagnostic safety events for learning and improvement.	o	o	o	o	o
b. Our diagnostic safety event data and results provide information sufficient for learnings.	o	o	o	o	o
c. Our diagnostic safety data and results provide information specific enough for use in improvement.	o	o	o	o	o
d. Diagnostic safety measurement activities are conducted in a way that safeguard the privacy and confidentiality of involved clinicians	o	o	o	o	o
e. Diagnostic safety measurement activities are conducted in a way that safeguard the privacy and confidentiality of involved patients	o	o	o	o	o
f. This office has enough resources to use diagnostic safety data for learning and improvement.	o	o	o	o	o
g. This office promotes awareness of diagnostic safety in the context of routine educational and operational functions	o	o	o	o	o
h. This office's leadership supports measurement of diagnostic safety events (e.g., event data, clinician reports, EHR chart review, patient information, etc.)	o	o	o	o	o
i. Diagnostic Safety Team members have support from others at this office who are also willing to learn in pursuit of diagnostic excellence	o	o	o	o	o

YOUR PERSPECTIVE ON THE WORK ENVIRONMENT IN YOUR OFFICE

We would like to know about your work environment in the office where you primarily work.

(9) Based on your experiences in the last 6 months, how much do you disagree or agree with the following statements ?

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree	Does Not Apply or Don't Know
a. In this office, we work together as an effective team	O	O	O	O	O	O
b. In this office, we have enough staff to handle our patient load.	O	O	O	O	O	O
c. When there is a problem in our office, we see if we need to change the way we do things.	O	O	O	O	O	O
d. This office is good at changing office processes to make sure the same problems don't happen again.	O	O	O	O	O	O
e. After this office makes changes to improve the patient care process, we check to see if the changes worked.	O	O	O	O	O	O

YOUR PERSPECTIVE ON COMMUNICATION IN YOUR OFFICE

We would like to know about communication in the office where you primarily work.

(10) How often do the following things happen in your office/work area?

	Never	Rarely	Some-times	Most of the time	Always	Does Not Apply or Don't Know
a. Providers in this office are open to staff ideas about how to improve office processes.	O	O	O	O	O	O
b. Staff are encouraged to express alternative viewpoints in this office.	O	O	O	O	O	O
c. Staff are afraid to ask questions when something does not seem right.	O	O	O	O	O	O
d. Staff feel like their mistakes are held against them.	O	O	O	O	O	O
e. Providers and staff talk openly about office problems.	O	O	O	O	O	O
f. It is difficult to voice disagreement in this office.	O	O	O	O	O	O

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g. In this office, we discuss ways to prevent errors from happening again.	o	o	o	o	o	o
h. Staff are willing to report mistakes they observe in this office.	o	o	o	o	o	o

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YOUR PERSPECTIVE ON PROCESSES AROUND DIAGNOSIS IN YOUR OFFICE

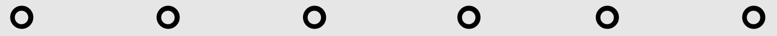
The following items ask about your office's processes around diagnosis. The processes start when a patient seeks care for a health problem and include:

- 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, as needed.

(11) 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
Time Availability						
a. The amount of time for appointments is long enough to fully evaluate the patient's presenting problem(s).	o	o	o	o	o	o
b. Providers in this office have enough time to review the relevant information related to the patient's presenting problem(s).	o	o	o	o	o	o
c. Providers in this office finish their patient notes by the end of their regular workday.	o	o	o	o	o	o
Testing and Referrals						
d. This office is effective at tracking a patient's test results from labs, imaging, and other diagnostic procedures.	o	o	o	o	o	o
e. When this office doesn't receive a patient's test results, staff follow up.	o	o	o	o	o	o
f. All test results are communicated to patients, even if the test results are normal.	o	o	o	o	o	o
g. When this office makes a high priority referral, we try to confirm whether the patient went to the appointment.	o	o	o	o	o	o
Provider and Staff Communication Around Diagnosis						
h. Providers in this office encourage staff to share their concerns about a patient's health condition.	o	o	o	o	o	o
i. Providers document differential diagnoses when they have **not** ruled out other diagnoses.	o	o	o	o	o	o
j. When a provider thinks another provider in this office/system may have missed a diagnosis, they inform that provider.	o	o	o	o	o	o
k. When a missed, wrong, or delayed diagnosis	o	o	o	o	o	o

happens in this office, we are informed about it.

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

(12) Is there anything else you'd like to share with us regarding ***your office's*** diagnostic safety measurement, review of diagnostic safety events and/or improvement efforts?

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We appreciate your involvement in this important effort.

Thank you!

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