

NATIONAL ACTION ALLIANCE
for Patient and Workforce Safety

Advancing Patient Safety Through Diagnostic Excellence

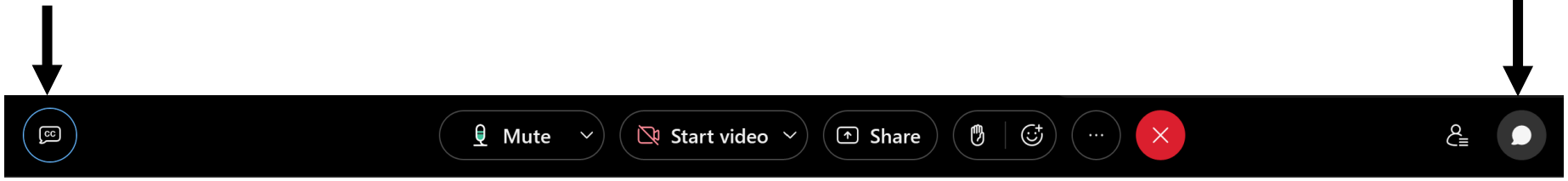
NATIONAL WEBINAR SERIES

September 17, 2024

Housekeeping Instructions

NATIONAL ACTION ALLIANCE for Patient and Workforce Safety

- This webinar will be recorded and available for viewing on the NAA website
- Please use the ‘Chat’ function to engage with us throughout the webinar and to ask any questions.
- Closed Captioning (CC) is available.



World Patient Safety Day 2024

NATIONAL ACTION ALLIANCE for Patient and Workforce Safety

World Patient Safety Day 17 September 2024

Improving diagnosis for patient safety

Get it right, make it safe!

- World Patient Safety Day is one of the World Health Organization's global public health days
- The 2024 theme is **improving diagnosis for patient safety**

Framing

NATIONAL ACTION ALLIANCE for Patient and Workforce Safety

- Diagnostic errors are common and costly, and they impact patient safety
- Consider the data:
  - 1 in 20 adults will experience a diagnostic error in the outpatient setting every year [a]
  - About 250,000 harmful diagnostic errors occur yearly in U.S. hospitals [b]
  - 79% of diagnostic errors are related to the patient-clinician encounter [c]
- Organizations can apply tools and strategies to reduce diagnostic errors

a. Singh H, Meyer AN, Thomas EJ. The frequency of diagnostic errors in outpatient care: estimations from three large observational studies involving US adult populations. BMJ Qual Saf. 2014 Sep;23(9):727-31.doi: 10.1136/bmjqs-2013-002627. Epub 2014 Apr 17.

b. Gunderson CG, Bilan VP, Holleck JL, Nickerson P, Cherry BM, Chui P, Bastian LA, Grimshaw AA, Rodwin BA. Prevalence of harmful diagnostic errors in hospitalised adults: a systematic review and meta-analysis. BMJ Qual Saf. 2020 Dec;29(12):1008-18. doi: 10.1136/bmjqs-2019-010822. Epub 2020 Apr 8.

c. Singh H, Giardina TD, Meyer AND, Forjuoh SN, Reis MD, Thomas EJ. Types and origins of diagnostic errors in primary care settings. JAMA Intern Med 2013;173(6):418-425. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3690001/. Accessed July 13, 2021.

AHRQ Tools to Improve Diagnostic Safety

NATIONAL ACTION ALLIANCE for Patient and Workforce Safety

- **TeamSTEPPS Diagnosis Improvement Course**
  - Team strategies and tools for optimizing patient outcomes
- **Calibrate Dx**
  - Self-evaluation tool for clinicians to improve their diagnostic decision-making
- **Measure Dx**
  - Resource to help healthcare organizations detect, analyze, and learn from diagnostic safety events
- **Toolkit for Engaging Patients to Improve Diagnostic Safety**
  - Resource to promote enhanced communication and information sharing within the patient-provider encounter to help patients, families, and health professionals work together as partners to improve diagnostic safety

Toolkits to be addressed in today's presentation.

All tools are available at https://www.ahrq.gov/diagnostic-safety/tools/index.html.

Questions to Run On

NATIONAL ACTION ALLIANCE for Patient and Workforce Safety

- What tools and resources are available to help organizations prevent diagnostic errors?

- What strategies can healthcare organizations implement to prevent diagnostic errors?

Share With Us

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What type of diagnostic errors are the top priority in your organization?

Speaker Welcome

Kelly Smith, PhD
Associate Professor, Institute of Health Policy, Management, & Evaluation
University of Toronto

Speaker Welcome

NATIONAL ACTION ALLIANCE for Patient and Workforce Safety

Hardeep Singh, MD, MPH
Co-Chief, Health Policy, Quality and Informatics Program,
Center for Innovations in Quality, Effectiveness and Safety
Michael E. DeBakey VA Medical Center and Baylor College of Medicine

AHRQ Toolkit for Engaging Patients To Improve Diagnostic Safety

Kelly M. Smith, PhD
Michael Garron Chair in Patient-Oriented Research and
Chief Scientific Officer, Michael Garron Hospital
Associate Professor, University of Toronto

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September 2024

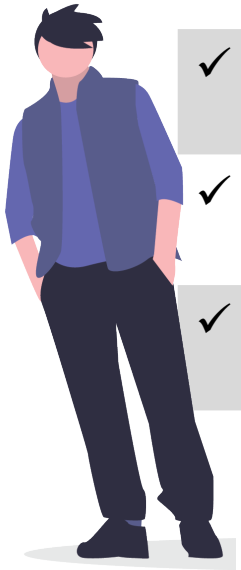
"Just listen to your patient, he is telling you the diagnosis."

- Sir William Osler

How can Patient Engagement improve Diagnostic Safety?

What can patients do?

- ✓ **Tell their story** fully and completely and clearly
- ✓ **Provide accurate information** about their symptoms
- ✓ **Speak up** if they feel they have not been heard
- ✓ **Ask questions** to clarify the information shared
- ✓ **Use a checklist** of tests, symptoms, concerns, or physicians consulted



What can clinicians do?

- ✓ **Listen** to patients
- ✓ **Support patients** in effectively sharing their symptoms.
- ✓ **Ask patients** what they think is going on
- ✓ **Conduct a thorough history** and physical examination
- ✓ **Set** a visit agenda
- ✓ **Know patients** and their history, and read prior notes
- ✓ **Integrate "pre-work"** for patients (e.g. symptoms; history of present illness; labs)

Toolkit Strategies

Optimize diagnostic safety by engaging patients and families.

Encourage patients to share their story with the **Be The Expert On You** note sheet.

Build a collaborative environment using the **60 Seconds To Improve Diagnostic Safety** strategy.

The Be The Expert On You Strategy

Be the expert on you.

Patient Name
DOB
Date

Your provider needs your help to make a safe diagnosis and care plan.
Please answer these five questions before your visit.

Why are you here today?
☐ New problem ☐ Followup ☐ Medicine refill ☐ Something else

Has there been a change in how you are feeling since your last visit?
☐ Yes ☐ No
When did it start? ☐ Days ☐ Weeks ☐ Longer
How does it affect you?

Have you seen anyone else about your health?
☐ Yes ☐ No
Whom did you see?

Do you have questions about...
☐ Medicines? ☐ Tests? ☐ Treatments? ☐ Something else?

What are you worried about?

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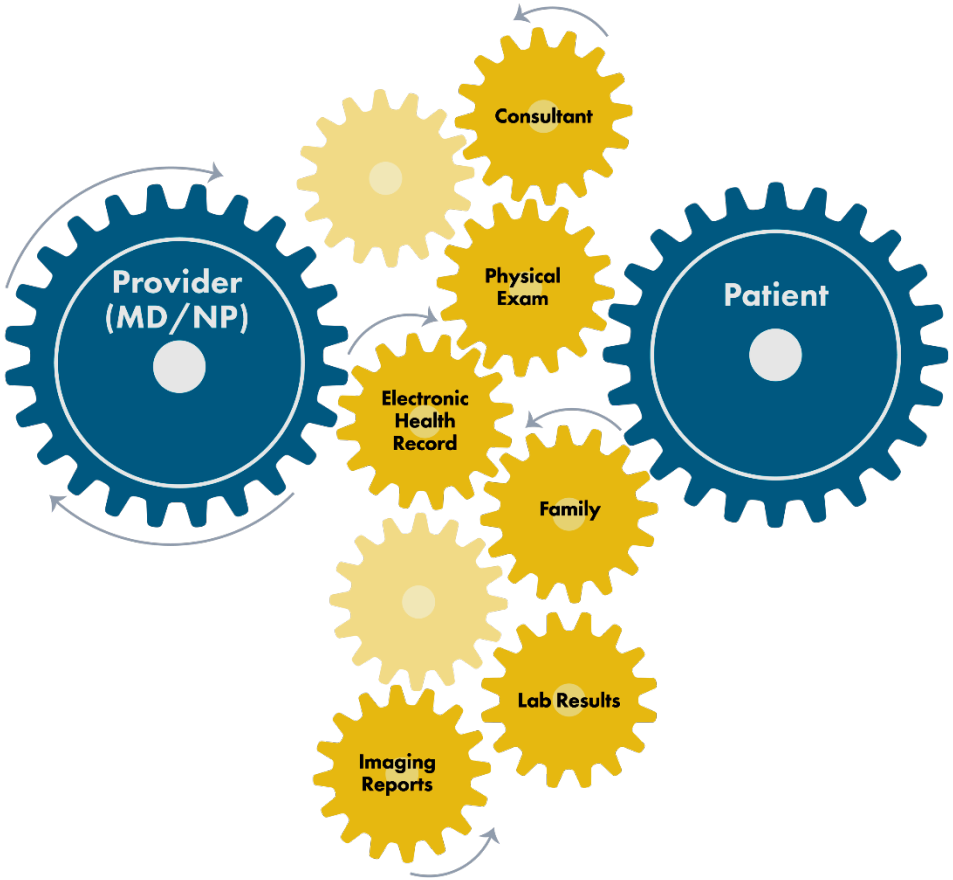
Be ready to share this information with your provider.

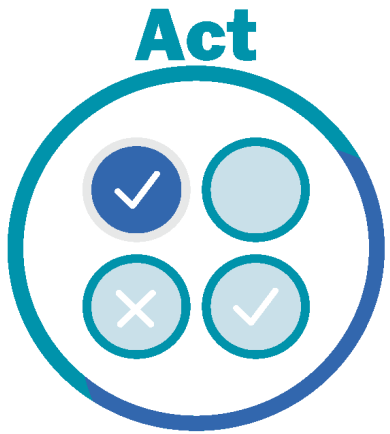
Thank you for being part of the care team.

Toolkit for Engaging Patients To Improve Diagnostic Safety | AHRQ Publication No. 21-0047-2-EF | August 2021

60 Seconds To Improve Diagnostic Safety Strategy

How Does 60 Seconds To Improve Diagnostic Safety Work?





60s for Diagnostic Safety
How Do I Get Started?

Ask

- What brings you in today?
- I would like to hear from you about how you are doing.

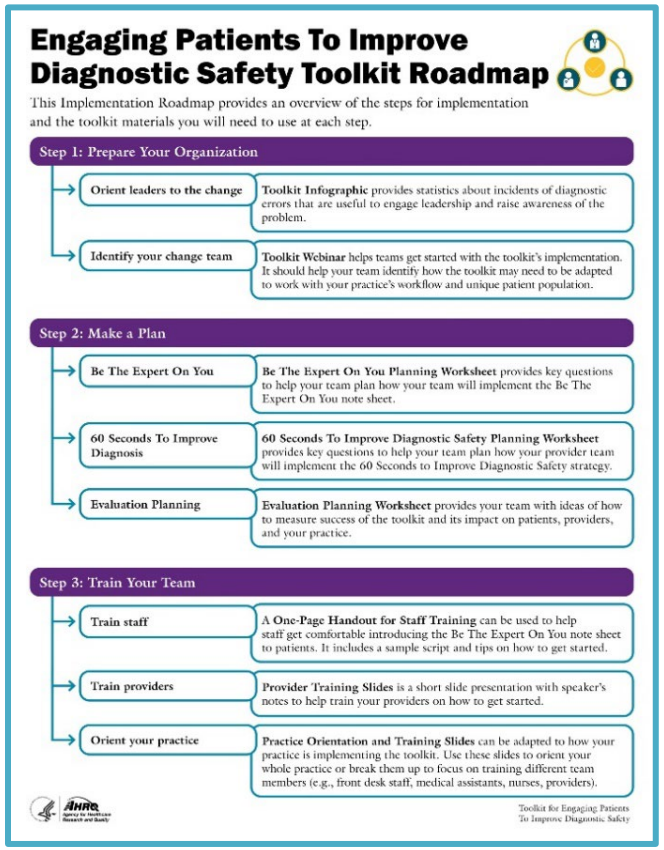
Listen

- Actively listen, encouraging engagement with "uh huhs"
- Write notes and make eye contact to show you are listening.

Act

- Use the information shared to cocreate a care plan.
- Ask additional questions to clarify information shared.

Toolkit Implementation Roadmap



Engaging Patients To Improve Diagnostic Safety Toolkit Roadmap

This Implementation Roadmap provides an overview of the steps for implementation and the toolkit materials you will need to use at each step.

Step 1: Prepare Your Organization

- **Orient leaders to the change** — **Toolkit Infographic** provides statistics about incidents of diagnostic errors that are useful to engage leadership and raise awareness of the problem.
- **Identify your change team** — **Toolkit Webinar** helps teams get started with the toolkit's implementation. It should help your team identify how the toolkit may need to be adapted to work with your practice's workflow and unique patient population.

Step 2: Make a Plan

- **Be The Expert On You** — **Be The Expert On You Planning Worksheet** provides key questions to help your team plan how your team will implement the Be The Expert On You note sheet.
- **60 Seconds To Improve Diagnosis** — **60 Seconds To Improve Diagnostic Safety Planning Worksheet** provides key questions to help your team plan how your provider team will implement the 60 Seconds to Improve Diagnostic Safety strategy.
- **Evaluation Planning** — **Evaluation Planning Worksheet** provides your team with ideas of how to measure success of the toolkit and its impact on patients, providers, and your practice.

Step 3: Train Your Team

- **Train staff** — **A One-Page Handout for Staff Training** can be used to help staff get comfortable introducing the Be The Expert On You note sheet to patients. It includes a sample script and tips on how to get started.
- **Train providers** — **Provider Training Slides** is a short slide presentation with speaker's notes to help train your providers on how to get started.
- **Orient your practice** — **Practice Orientation and Training Slides** can be adapted to how your practice is implementing the toolkit. Use these slides to orient your whole practice or break them up to focus on training different team members (e.g., front desk staff, medical assistants, nurses, providers).

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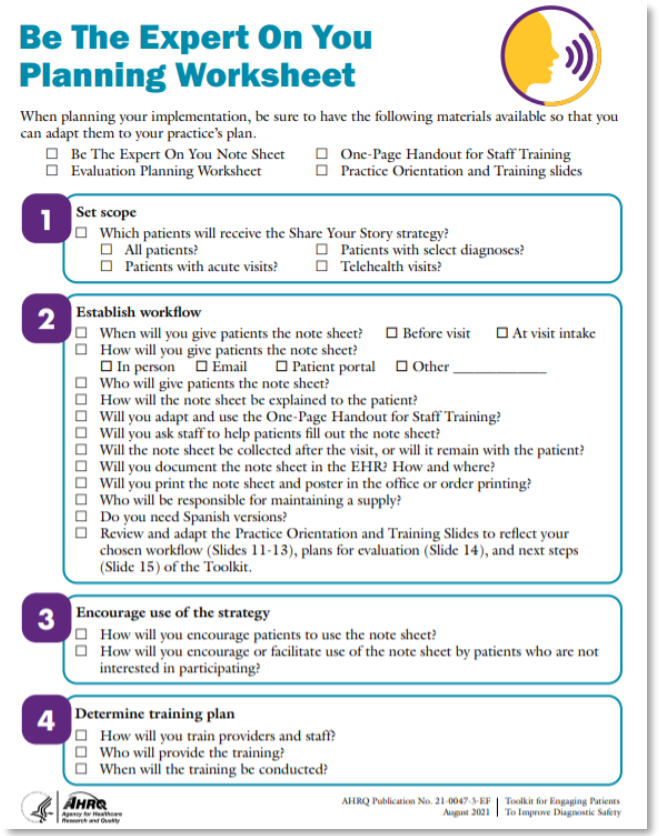
Toolkit for Engaging Patients To Improve Diagnostic Safety

Planning Worksheets



Be The Expert On You Planning Worksheet

When planning your implementation, be sure to have the following materials available so that you can adapt them to your practice's plan.

- ☐ Be The Expert On You Note Sheet
- ☐ Evaluation Planning Worksheet
- ☐ One-Page Handout for Staff Training
- ☐ Practice Orientation and Training slides

1 Set scope

- ☐ Which patients will receive the Share Your Story strategy?
  - ☐ All patients?
  - ☐ Patients with acute visits?
  - ☐ Patients with select diagnoses?
  - ☐ Telehealth visits?

2 Establish workflow

- ☐ When will you give patients the note sheet? ☐ Before visit ☐ At visit intake
- ☐ How will you give patients the note sheet?
  ☐ In person ☐ Email ☐ Patient portal ☐ Other _____
- ☐ Who will give patients the note sheet?
- ☐ How will the note sheet be explained to the patient?
- ☐ Will you adapt and use the One-Page Handout for Staff Training?
- ☐ Will you ask staff to help patients fill out the note sheet?
- ☐ Will the note sheet be collected after the visit, or will it remain with the patient?
- ☐ Will you document the note sheet in the EHR? How and where?
- ☐ Will you print the note sheet and poster in the office or order printing?
- ☐ Who will be responsible for maintaining a supply?
- ☐ Do you need Spanish versions?
- ☐ Review and adapt the Practice Orientation and Training Slides to reflect your chosen workflow (Slides 11-13), plans for evaluation (Slide 14), and next steps (Slide 15) of the Toolkit.

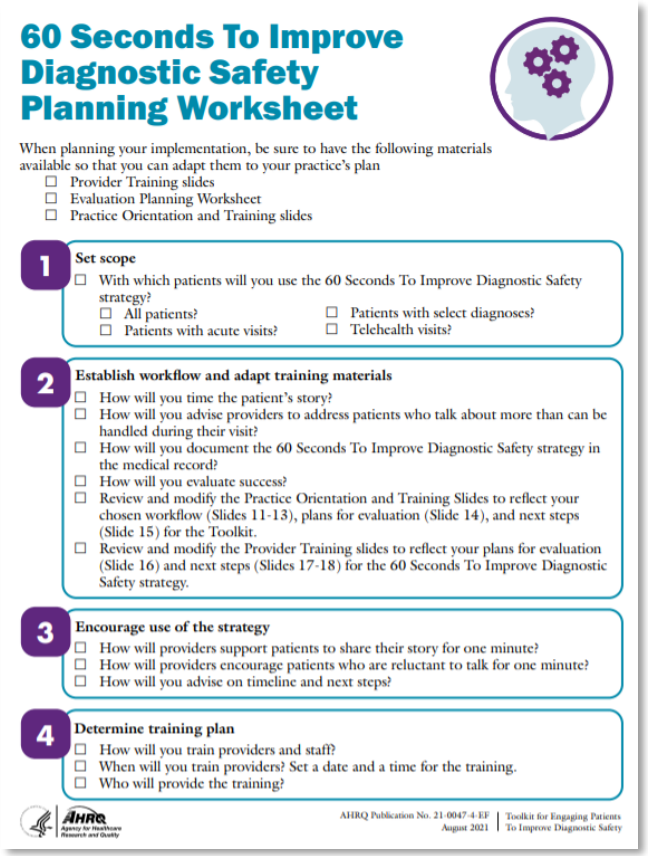
3 Encourage use of the strategy

- ☐ How will you encourage patients to use the note sheet?
- ☐ How will you encourage or facilitate use of the note sheet by patients who are not interested in participating?

4 Determine training plan

- ☐ How will you train providers and staff?
- ☐ Who will provide the training?
- ☐ When will the training be conducted?

AHRQ Publication No. 21-0047-3-EF | August 2021 | Toolkit for Engaging Patients To Improve Diagnostic Safety



60 Seconds To Improve Diagnostic Safety Planning Worksheet

When planning your implementation, be sure to have the following materials available so that you can adapt them to your practice's plan

- ☐ Provider Training slides
- ☐ Evaluation Planning Worksheet
- ☐ Practice Orientation and Training slides

1 Set scope

- ☐ With which patients will you use the 60 Seconds To Improve Diagnostic Safety strategy?
  - ☐ All patients?
  - ☐ Patients with acute visits?
  - ☐ Patients with select diagnoses?
  - ☐ Telehealth visits?

2 Establish workflow and adapt training materials

- ☐ How will you time the patient's story?
- ☐ How will you advise providers to address patients who talk about more than can be handled during their visit?
- ☐ How will you document the 60 Seconds To Improve Diagnostic Safety strategy in the medical record?
- ☐ How will you evaluate success?
- ☐ Review and modify the Practice Orientation and Training Slides to reflect your chosen workflow (Slides 11-13), plans for evaluation (Slide 14), and next steps (Slide 15) for the Toolkit.
- ☐ Review and modify the Provider Training slides to reflect your plans for evaluation (Slide 16) and next steps (Slides 17-18) for the 60 Seconds To Improve Diagnostic Safety strategy.

3 Encourage use of the strategy

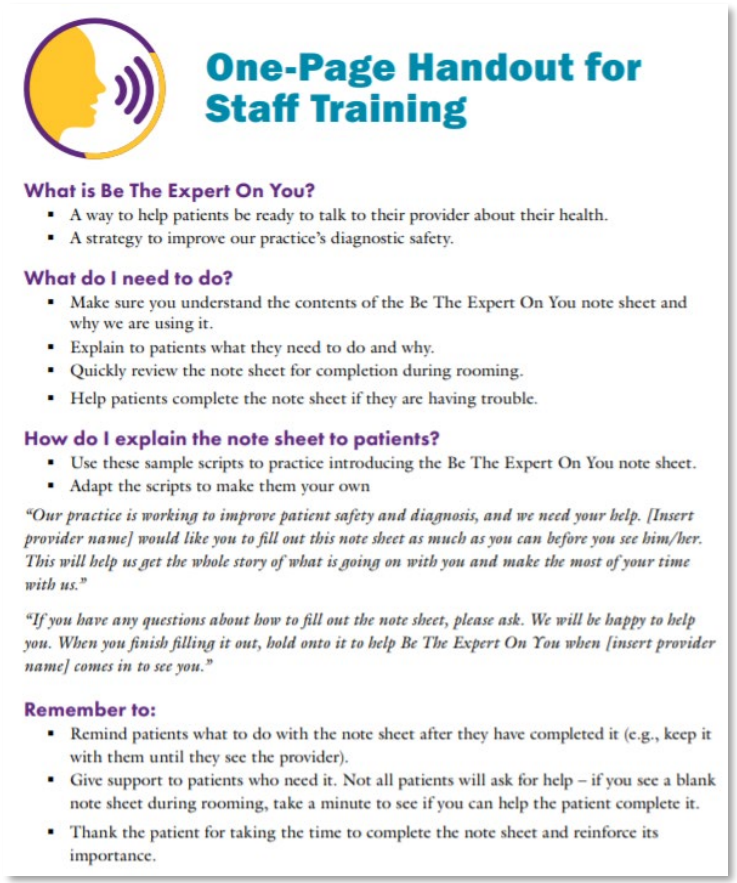
- ☐ How will providers support patients to share their story for one minute?
- ☐ How will providers encourage patients who are reluctant to talk for one minute?
- ☐ How will you advise on timeline and next steps?

4 Determine training plan

- ☐ How will you train providers and staff?
- ☐ When will you train providers? Set a date and a time for the training.
- ☐ Who will provide the training?

AHRQ Publication No. 21-0047-4-EF | August 2021 | Toolkit for Engaging Patients To Improve Diagnostic Safety

Train Your Team



One-Page Handout for Staff Training

What is Be The Expert On You?

- A way to help patients be ready to talk to their provider about their health.
- A strategy to improve our practice's diagnostic safety.

What do I need to do?

- Make sure you understand the contents of the Be The Expert On You note sheet and why we are using it.
- Explain to patients what they need to do and why.
- Quickly review the note sheet for completion during rooming.
- Help patients complete the note sheet if they are having trouble.

How do I explain the note sheet to patients?

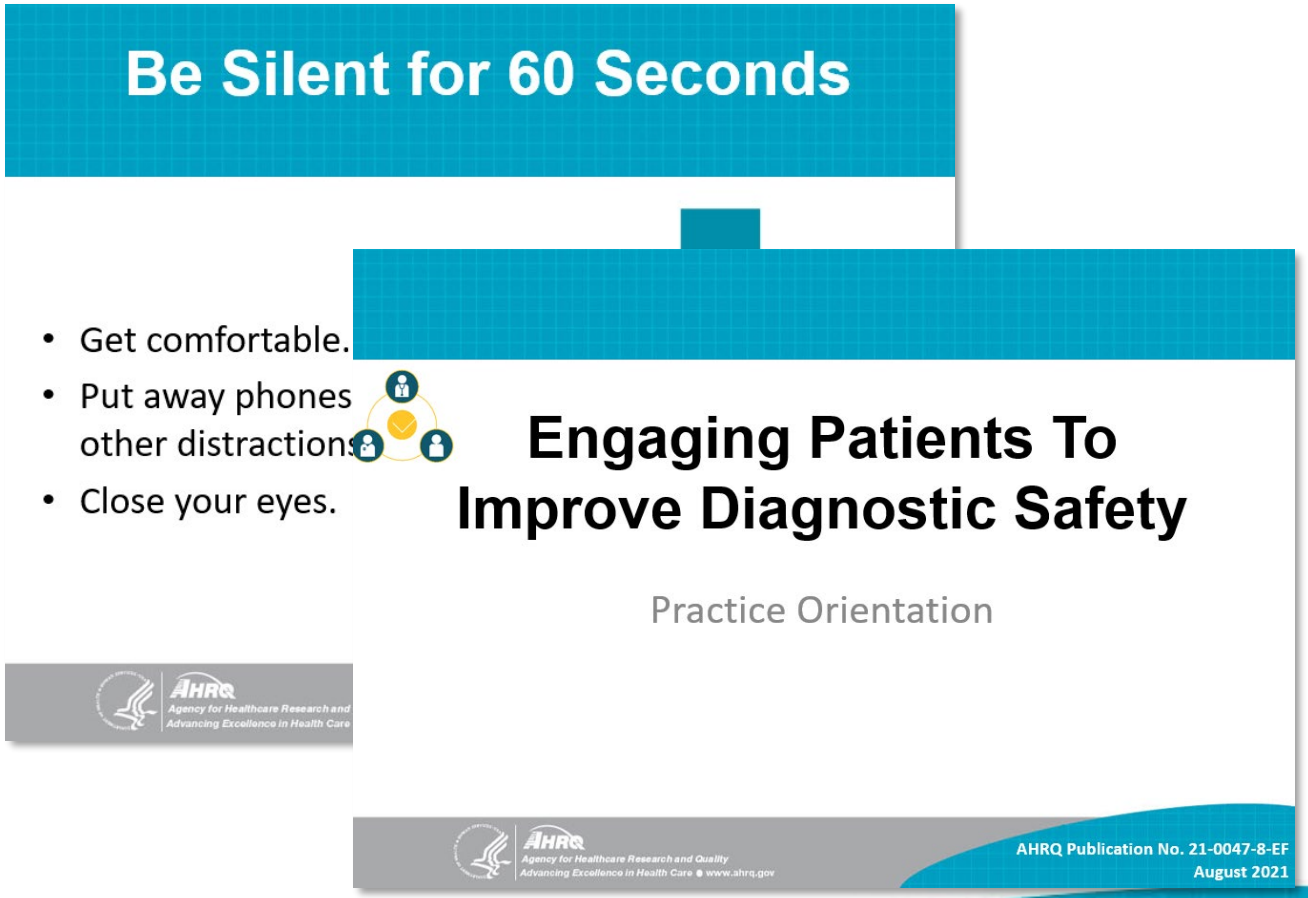
- Use these sample scripts to practice introducing the Be The Expert On You note sheet.
- Adapt the scripts to make them your own

"Our practice is working to improve patient safety and diagnosis, and we need your help. [Insert provider name] would like you to fill out this note sheet as much as you can before you see him/her. This will help us get the whole story of what is going on with you and make the most of your time with us."

"If you have any questions about how to fill out the note sheet, please ask. We will be happy to help you. When you finish filling it out, hold onto it to help Be The Expert On You when [insert provider name] comes in to see you."

Remember to:

- Remind patients what to do with the note sheet after they have completed it (e.g., keep it with them until they see the provider).
- Give support to patients who need it. Not all patients will ask for help – if you see a blank note sheet during rooming, take a minute to see if you can help the patient complete it.
- Thank the patient for taking the time to complete the note sheet and reinforce its importance.



Be Silent for 60 Seconds

- Get comfortable.
- Put away phones other distractions
- Close your eyes.

Engaging Patients To Improve Diagnostic Safety

Practice Orientation

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AHRQ Publication No. 21-0047-8-EF
August 2021

Sample Workflow: Be The Expert On You Note Sheet

In Person: Front Desk Team introduces the note sheet

Patients complete the note sheet

Patients use note sheet to share their story

Telehealth: Send the note sheet via the patient portal or e-mail

Lessons Learned

Improved relationships with patients leading to improved experience and safety

Clear, concise, correct, and complete information to make diagnostic decisions

Enhanced connection and reduced technical burnout

A return to the joy of healing

Measure Dx:

A Resource To Identify, Analyze, and Learn From Diagnostic Safety Events

Andrea Bradford, Ph.D.
Hardeep Singh, MD, MPH

CENTER FOR INNOVATIONS IN QUALITY, EFFECTIVENESS & SAFETY (IQUEST)
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Foundation for Improvement

A Learning Health System for Diagnostic Safety

The Safer Dx Checklist

10 High-Priority Practices for Diagnostic Excellence

PREPARED BY:

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ACKNOWLEDGMENTS

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Safer Dx Checklist

The Safer Dx Checklist:
10 High-Priority Practices for Diagnostic Excellence

(Scenarios are examples of actions to improve the practices)

		Implementation Status (Current state of organization's practices)		
		Full	Partial	Not Implemented
1	**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.** Scenario 1: Senior leadership/C-suite establish a multidisciplinary team (e.g., diagnostic safety committee) charged with identifying and addressing opportunities to reduce errors at the institutional level. The team includes department leaders and clinical champions. Scenario 2: Senior leadership/C-suite consistently share diagnostic safety data with the governance board. This includes quantitative data to measure and track diagnostic safety as well as narrative patient stories, patterns, and action plans.	☐	☐	☐
2	**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.** Scenario: Ensure non-punitive conditions that encourage clinical and non-clinical staff to report missed opportunities, harms, "good catches," tips, and lessons related to diagnostic safety. Close the loop and share information on corrective actions or steps taken to prevent recurrence in a timely and effective manner.	☐	☐	☐
	Health care organization creates feedback loops to increase information flow about	☐	☐	☐

The Safer Dx Checklist
10 High-Priority Practices for Diagnostic Excellence

The Safer Dx Checklist is an organizational self-assessment tool with 10 recommended practices to achieve diagnostic excellence.

Why Use the Checklist?

Diagnostic errors (missed, delayed, or wrong diagnoses) involve at least 1 in 20 US adults annually and lead to considerable harm to patients of all ages. They also are costly and one of the most common reasons for malpractice claims. Health care organizations need pragmatic guidance on where to focus efforts to improve diagnostic safety.

The Safer Dx Checklist is a synthesis of foundational practices that health care organizations can use to advance diagnostic excellence. The checklist provides a framework for organizations to conduct a self-assessment to understand the current state of diagnostic practices, identify areas to improve, and track progress toward diagnostic excellence over time.

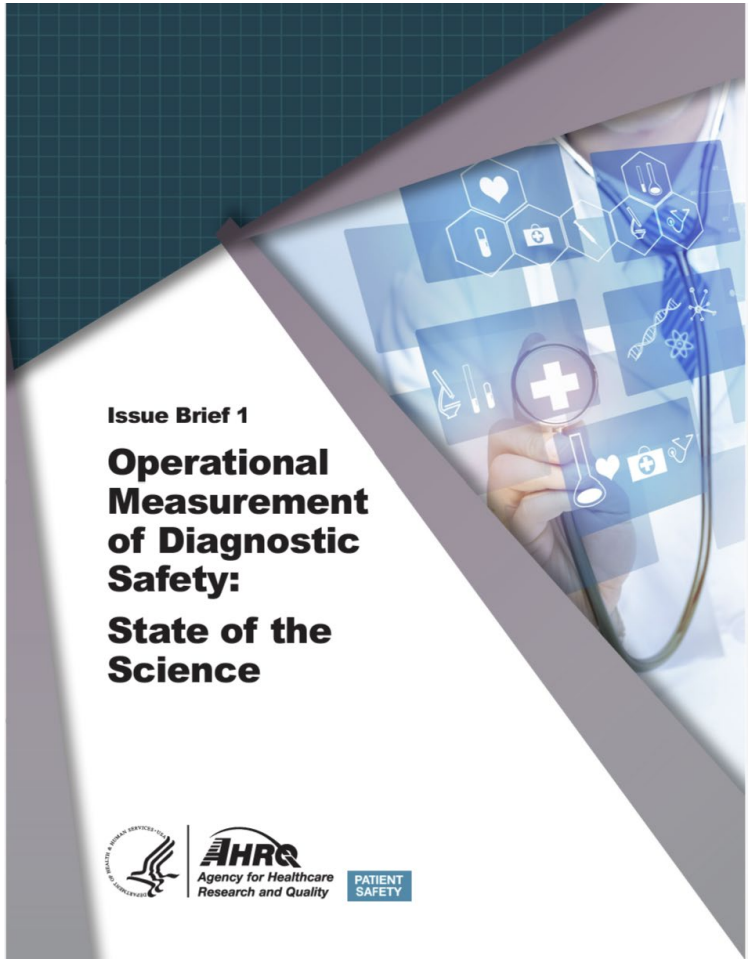
The checklist was developed using a rigorous multimethod approach that included interviews with health care quality and safety leaders,

How to Use the Checklist

1. **Identify a senior leader** (e.g., chief quality officer, chief patient safety officer, chief medical officer, or other clinician with oversight of quality) in the organization who can serve as the champion for learning and exploration of diagnostic excellence.
2. **Establish a multidisciplinary team** of individuals from various clinical and non-clinical disciplines, including quality and safety, patient

Introduction to Measure Dx

- AHRQ-funded resource to help health care organizations identify and learn from diagnostic safety events
- Grounded in an AHRQ Issue Brief on operational measurement
- Co-developed with national experts
- Released to the public in July 2022



https://www.ahrq.gov/diagnostic-safety/resources/issue-briefs.html

Overview of Measure Dx

1 Prepare for Measurement

- Engage stakeholders
- Build a team
- Foster psychological safety

2 Conduct a Self-assessment

Take inventory of available resources to support this work & select a feasible measurement strategy

3 Implement Measurement Strategies

Use one or more data sources within the organization to capture potential diagnostic safety events for further review

4 Review & Analyze Cases

Use a systematic review process to identify learning opportunities and translate findings into useful feedback

Case Finding Strategies in Measure Dx

n = 156

USE EXISTING QUALITY & SAFETY DATA

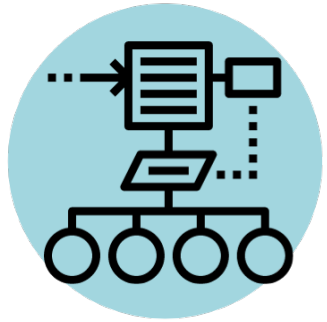
n = 12

SOLICIT REPORTS FROM CLINICIANS

n = 14

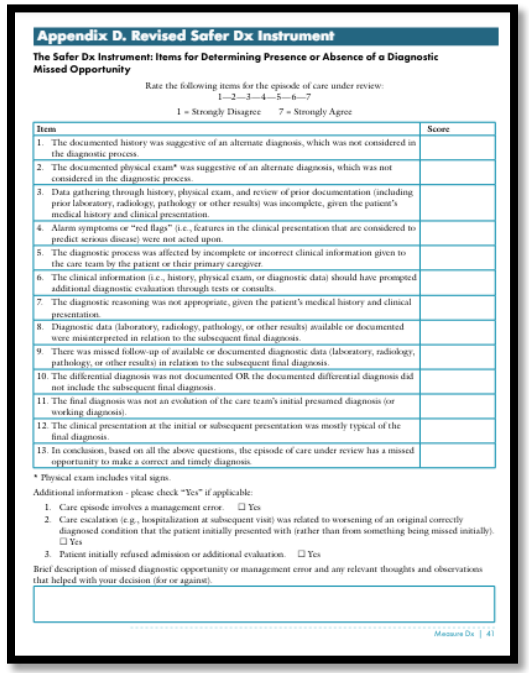
LEVERAGE PATIENT-REPORTED DATA

n = 521



EHR-ENHANCED CHART REVIEW

Systematic record review to identify learning opportunities (n=703)



Appendix D. Revised Safer Dx Instrument

The Safer Dx Instrument: Items for Determining Presence or Absence of a Diagnostic Missed Opportunity

Rate the following items for the episode of care under review:
1—2—3—4—5—6—7

1 = Strongly Disagree 7 = Strongly Agree

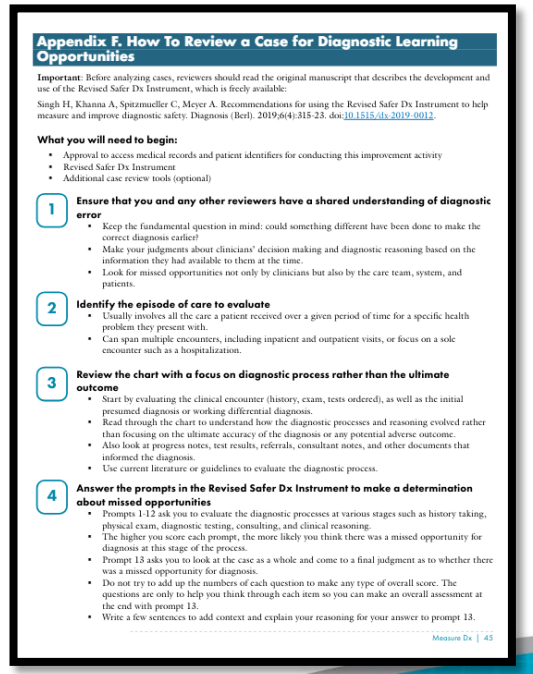
Item	Score
1. The documented history was suggestive of an alternate diagnosis, which was not considered in the diagnostic process.	
2. The documented physical exam* was suggestive of an alternate diagnosis, which was not considered in the diagnostic process.	
3. Data gathering through history, physical exam, and review of prior documentation (including prior laboratory, radiology, pathology or other results) was incomplete, given the patient's medical history and clinical presentation.	
4. Alarm symptoms or "red flags" (i.e., features in the clinical presentation that are considered to predict serious disease) were not acted upon.	
5. The diagnostic process was affected by incomplete or incorrect clinical information given to the care team by the patient or their primary caregiver.	
6. The clinical information (i.e., history, physical exam, or diagnostic data) should have prompted additional diagnostic evaluation through tests or consults.	
7. The diagnostic reasoning was not appropriate, given the patient's medical history and clinical presentation.	
8. Diagnostic data (laboratory, radiology, pathology, or other results) available or documented were misinterpreted in relation to the subsequent final diagnosis.	
9. There was missed follow-up of available or documented diagnostic data (laboratory, radiology, pathology, or other results) in relation to the subsequent final diagnosis.	
10. The differential diagnosis was not documented OR the documented differential diagnosis did not include the subsequent final diagnosis.	
11. The final diagnosis was not an evolution of the care team's initial presumed diagnosis (or working diagnosis).	
12. The clinical presentation at the initial or subsequent presentation was mostly typical of the final diagnosis.	
13. In conclusion, based on all the above questions, the episode of care under review has a missed opportunity to make a correct and timely diagnosis.	

* Physical exam includes vital signs.

Additional information - please check "Yes" if applicable:

1. Care episode involves a management error. ☐ Yes
2. Care escalation (e.g., hospitalization at subsequent visit) was related to worsening of an original correctly diagnosed condition that the patient initially presented with (rather than from something being missed initially). ☐ Yes
3. Patient initially refused admission or additional evaluation. ☐ Yes

Brief description of missed diagnostic opportunity or management error and any relevant thoughts and observations that helped with your decision (for or against).



Appendix F. How To Review a Case for Diagnostic Learning Opportunities

Important: Before analyzing cases, reviewers should read the original manuscript that describes the development and use of the Revised Safer Dx Instrument, which is freely available:

Singh H, Khanna A, Spitzmueller C, Meyer A. Recommendations for using the Revised Safer Dx Instrument to help measure and improve diagnostic safety. Diagnosis (Berl). 2019;6(4):315-23. doi:10.1515/dx-2019-0012.

What you will need to begin:

- Approval to access medical records and patient identifiers for conducting this improvement activity
- Revised Safer Dx Instrument
- Additional case review tools (optional)

1 Ensure that you and any other reviewers have a shared understanding of diagnostic error

- Keep the fundamental question in mind: could something different have been done to make the correct diagnosis earlier?
- Make your judgments about clinicians' decision making and diagnostic reasoning based on the information they had available to them at the time.
- Look for missed opportunities not only by clinicians but also by the care team, system, and patients.

2 Identify the episode of care to evaluate

- Usually involves all the care a patient received over a given period of time for a specific health problem they present with.
- Can span multiple encounters, including inpatient and outpatient visits, or focus on a sole encounter such as a hospitalization.

3 Review the chart with a focus on diagnostic process rather than the ultimate outcome

- Start by evaluating the clinical encounter (history, exam, tests ordered), as well as the initial presumed diagnosis or working differential diagnosis.
- Read through the chart to understand how the diagnostic processes and reasoning evolved rather than focusing on the ultimate accuracy of the diagnosis or any potential adverse outcome.
- Also look at progress notes, test results, referrals, consultant notes, and other documents that informed the diagnosis.
- Use current literature or guidelines to evaluate the diagnostic process.

4 Answer the prompts in the Revised Safer Dx Instrument to make a determination about missed opportunities

- Prompts 1-12 ask you to evaluate the diagnostic processes at various stages such as history taking, physical exam, diagnostic testing, consulting, and clinical reasoning.
- The higher you score each prompt, the more likely you think there was a missed opportunity for diagnosis at this stage of the process.
- Prompt 13 asks you to look at the case as a whole and come to a final judgment as to whether there was a missed opportunity for diagnosis.
- Do not try to add up the numbers of each question to make any type of overall score. The questions are only to help you think through each item so you can make an overall assessment at the end with prompt 13.
- Write a few sentences to add context and explain your reasoning for your answer to prompt 13.

Examples of What Teams Learned

DIAGNOSES/ERROR TYPES REVIEWED

Sepsis/septic shock
Child physical abuse
Infections
Biphasic anaphylaxis
Missed follow-up of test results
Delayed communication of dx

ACTIONS TAKEN AFTER CASE REVIEW

Escalation to leadership
Referral to other quality/safety committee
Feedback to involved clinicians
Feedback to inform clinical care pathways
Routine report to identify cases needing action
Creation of diagnostic error database

Examples of What Teams Learned

DIAGNOSES/ERROR TYPES REVIEWED

Sepsis/septic shock
Child physical abuse
Infections
Biphasic anaphylaxis
Missed follow-up of test results
Delayed communication of dx

ACTIONS TAKEN AFTER CASE REVIEW

Escalation to leadership
Referral to other quality/safety committee
Feedback to involved clinicians
Feedback to inform clinical care pathways
Routine report to identify cases needing action
Creation of diagnostic error database

Recommendations from Participants

Lesson 1: Start Small

"Be realistic… it's very easy to try to bite off more than yc can handle."

"Don't be overwhelmed by the amount. Just start somewhere."

"Try to scope the work so that it's really feasible… within relatively short amount of time…"

Recommendations from Participants

Lesson 2: Leadership is Key

"Engaging leadership from the top was really key for us"

"Having a good leader was actually kind of nice… getting this started and realizing this is important."

"…the biggest struggles… is just continuing to get buy-in from executive leadership."

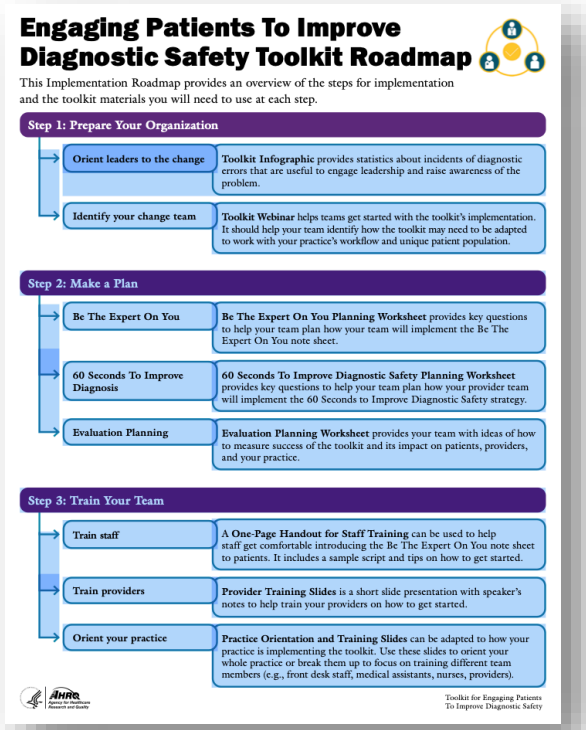
Recommendations from Participants

Lesson 3: Work With What You Have

"We systematically track… patient safety events, but how much of them are due to diagnostic errors? We do not have that part."

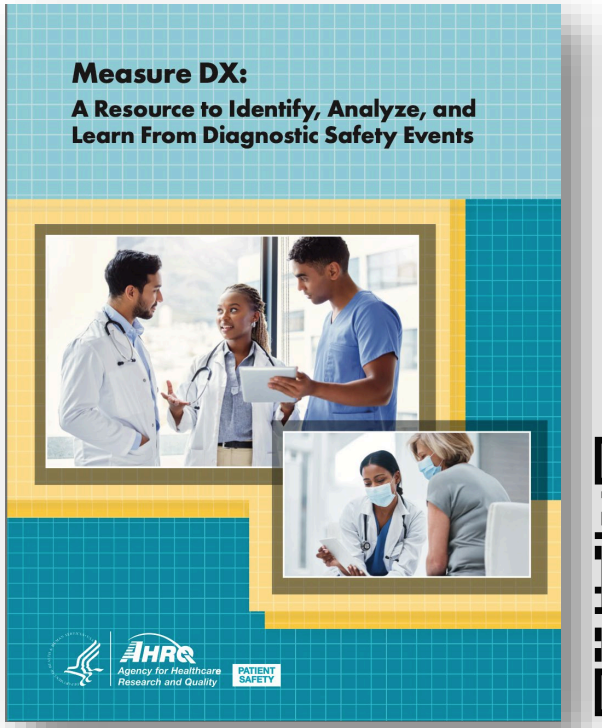
"Adapting your preexisting patient safety and quality infrastructure is probably the way to go, without spending a ton of money and redesigning… the processes, the policies…"

Diagnostic Safety Resources



Toolkit for Engaging Patients To Improve Diagnostic Safety

https://www.ahrq.gov/diagnostic-safety/tools/engaging-patients-improve.html



Measure Dx

https://www.ahrq.gov/patient-safety/settings/multiple/measure-dx.html

Speaker Welcome

Sangeeta C. Ahluwalia
Associate Director & Senior Researcher, RAND Corporation

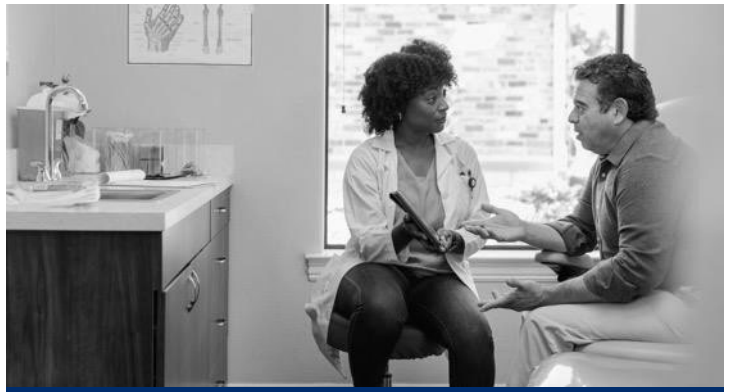
Cecilie_Arcurs/Getty Images

Implementing Diagnostic Excellence Across Systems (IDEAS) Project

Agency for Healthcare Research and Quality

PATIENT SAFETY

IDEAS supports diagnostic safety across settings and users



Toolkit for Engaging Patients To Improve Diagnostic Safety

Measure Dx

Calibrate Dx

	Toolkit for Engaging Patients To Improve Diagnostic Safety	Measure Dx	Calibrate Dx
SETTING	Office-based setting	Any healthcare setting	Any healthcare setting
USERS	Clinicians and their patients	QI or patient safety teams	Individual licensed clinicians whose scope of practice includes diagnosis

Interested? Contact us:
IDEASproject@rand.org

Resource-specific considerations

March 2025

Toolkit for Patient Engagement

- Two to three clinician participants to use the resource in routine practice
- Participate in data collection activities for the evaluation
- Involvement of administrative office staff to collect brief, anonymous patient surveys

June 2025

Measure Dx

- QI team with (1) a clinical lead with diagnostic expertise and (2) a quality manager with operations expertise
- Participate in data collection activities, many of which could be done during QI meetings or scheduled activities

August 2025

Calibrate Dx

- Four to six clinician participants who perform quarterly reviews of a sample of their own cases
- Complete brief quarterly surveys and provide feedback on the resource
- Clinician access to electronic health record data for case reviews

Interested? Contact us:
IDEASproject@rand.org

Why participate in IDEAS?

- Implement innovative methods for advancing diagnostic safety
- Receive tailored support to implement the AHRQ resources
  - Flexible training for including resource-specific materials and tip sheets
  - CE credits and ABMS-approved MOC credits
  - Hands-on assistance including dedicated email for questions and “office hours” with content experts
  - Learning Collaboratives with other participants
  - Feedback on the impact of the intervention (available to participants at end of study)
- Receive a modest stipend

Interested? Contact us:
IDEASproject@rand.org

Question & Answers

Let us know!

NATIONAL ACTION ALLIANCE for Patient and Workforce Safety

Based on what you have learned today,

What type of diagnostic errors are the top priority in your organization?

***Please submit your response in the chat**

Upcoming Events of Interest

Upcoming Webinar hosted by The Leapfrog Group
Achieving Diagnostic Excellence: Resources for Hospitals

NATIONAL ACTION ALLIANCE for Patient and Workforce Safety

October 18, 1:00 pm EST- Registration Link

Three-part presentation on resources and strategies available to hospitals pursuing diagnostic excellence directly related to Leapfrog's ongoing initiative to recognize hospitals that excel at preventing harm from diagnostic errors.

THE LEAPFROG GROUP

Speakers:

Courtney Gidengil, MD, MPH, Senior Physician Policy Researcher with RAND

Mark Graber, MD, Founder and President Emeritus of the Society to Improve Diagnosis in Medicine

Jean-Luc Tilly, MPA, Program Manager at The Leapfrog Group

Thank You!

Announcing the Next NAA Monthly National Webinar

Workforce Safety and Well-Being Webinar Series

(Session 1): Leadership Strategies that Improve Workforce Safety and Well-Being

Tuesday, October 8, 2024 (Noon- 1:00 PM ET)

Registration is open and can be found on the NAA website

https://cma.ahrq.gov/NAAOCT2024

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