

References



Implementation Roadmap

1. Practice Facilitation Handbook. Content last reviewed May 2018. Agency for Healthcare Research and Quality, Rockville, MD. <https://www.ahrq.gov/ncepcr/tools/pf-handbook/index.html>.

Toolkit Infographic

1. CRICO Strategies, 2014 Annual Benchmarking Report: Malpractice Risks in the Diagnostic Process. Cambridge, MA: Harvard Medical Institutions; 2015. <https://www.rmfi.harvard.edu/Malpractice-Data/Annual-Benchmark-Reports/Risks-in-the-Diagnostic-Process>. Accessed July 13, 2021.
2. National Academies of Sciences, Engineering, and Medicine. Improving Diagnosis in Health Care. Washington, DC: National Academies Press; 2015. <https://www.nap.edu/catalog/21794/improving-diagnosis-in-health-care>. Accessed July 13, 2021.
3. 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.

Toolkit Webinar

- TBD

Evaluation Planning Worksheet

1. Singh H, Bradford A, Goeschel C. *Operational Measurement of Diagnostic Safety: State of the Science*. Rockville, MD; 2020. <https://www.ahrq.gov/patient-safety/reports/issue-briefs/state-of-science.html>.
2. CAHPS Health Literacy Item Sets. Content last reviewed January 2018. Agency for Healthcare Research and Quality, Rockville, MD. <https://www.ahrq.gov/cahps/surveys-guidance/item-sets/literacy/index.html>.
3. Medical Office Survey on Patient Safety Culture. Content last reviewed May 2021. Agency for Healthcare Research and Quality, Rockville, MD. <https://www.ahrq.gov/sops/surveys/medical-office/index.html>.
4. Diagnostic Safety Supplemental Items for Medical Office SOPS. Content last reviewed April 2021. Agency for Healthcare Research and Quality, Rockville, MD. <https://www.ahrq.gov/sops/surveys/medical-office/supplemental-items/diagnostic-safety.html>.

Provider Training slides

1. Bliss M. William Osler: A Life in Medicine. Oxford, UK: Oxford University Press; 2000
2. Singh Ospina N, Phillips KA, Rodriguez-Gutierrez R, Castaneda-Guarderas A, Gionfriddo MR, Branda ME, Montori VM. Eliciting the patient's agenda - secondary analysis of recorded clinical encounters. *J Gen Intern Med*. 2019;34(1):36-40. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6318197/>. Accessed July 19, 2021.
3. Shields CG, Epstein RM, Fiscella K, Franks P, McCann R, McCormick K, Mallinger JB. Influence of accompanied encounters on patient-centeredness with older patients. *J Am Board Fam Pract*. 2005;18(5):344-54. <https://www.jabfm.org/content/18/5/344.long>. Accessed July 19, 2021.
4. Singh H, Giardina TD, Meyer AN, 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 19, 2021.
5. Committee on Diagnostic Error in Health Care; Board on Health Care Services; Institute of Medicine; The National Academies of Sciences, Engineering, and Medicine. *Improving Diagnosis in Health Care*. Balogh EP, Miller BT, Ball JR, eds. Washington, DC: National Academies Press; 2015. <https://www.ncbi.nlm.nih.gov/books/NBK338596/>. Accessed July 19, 2021.
6. Bartels J, Rodenbach R, Ciesinski K, Gramling R, Fiscella K, Epstein R. Eloquent silences: a musical and lexical analysis of conversation between oncologists and their patients. *Patient Educ Couns*. 2016 Oct;99(10):1584-94. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6100772/>. Accessed July 19, 2021.

7. Ofri D, Trimboli O. Deep Listening: Impact Beyond Words - Why Your Doctor Needs To Listen Deeply. <https://www.oscartrimboli.com/podcast/044/>. Accessed July 19, 2021.
8. Zulman DM, Haverfield MC, Shaw JG, Brown-Johnson CG, Schwartz R, Tierney AA, Zions DL, Safaeinili N, Fischer M, Thadaney Israni S, Asch SM, Verghese A. Practices to foster physician presence and connection with patients in the clinical encounter. *JAMA*. 2020 Jan 7;323(1):70-81. Erratum in: *JAMA*. 2020 Mar 17;323(11):1098. <https://pubmed.ncbi.nlm.nih.gov/31910284/>. Accessed July 19, 2021.
9. Goss AL. How becoming a doctor made me a worse listener. *JAMA*. 2020;323(11):1041. <https://doi.org/10.1001/jama.2020.2051>. Accessed July 19, 2021.
10. Swendiman RA. Deep listening. *Acad Med*. 2014;89(6):950. <https://doi.org/10.1097/ACM.0000000000000238>. Accessed July 19, 2021.
11. Doyle A. Important Active Listening Skills and Techniques. New York, NY: The Balance Careers; 2019. <https://www.thebalancecareers.com/active-listening-skills-with-examples-2059684>. Accessed July 19, 2021.
12. Schwartz A, Weiner SJ, Weaver F, Yudkowsky R, Sharma G, Binns-Calvey A, Preyss B, Jordan N. Uncharted territory: measuring costs of diagnostic errors outside the medical record. *BMJ Qual Saf*. 2012;21(11):918-24. <https://pubmed.ncbi.nlm.nih.gov/22773889/>. Accessed July 19, 2021.
13. Weiner SJ, Schwartz A, Weaver F, Goldberg J, Yudkowsky R, Sharma G, Binns-Calvey A, Preyss B, Schapira MM, Persell SD, Jacobs E, Abrams RI. Contextual errors and failures in individualizing patient care: A multicenter study. *Ann Intern Med*. 2010;153(2):69-75. <https://www.acpjournals.org/doi/10.7326/0003-4819-153-2-201007200-00002>. Accessed July 19, 2021.

Practice Orientation and Training slides

1. Hoffman J, ed. 2014 Annual Benchmarking Report: Malpractice Risks in the Diagnostic Process. Cambridge, MA: CRICO Strategies; 2015. <https://www.rmhf.harvard.edu/Malpractice-Data/Annual-Benchmark-Reports/Risks-in-the-Diagnostic-Process>. Accessed July 20, 2021.
2. National Academy of Medicine. Improving Diagnosis in Health Care. Balogh EP, Miller BT, Ball JR, eds.. Washington, DC: National Academies Press; 2015. <https://pubmed.ncbi.nlm.nih.gov/26803862/>. Accessed July 20, 2021.
3. Singh H, Giardina TD, Meyer AN, Forjuoh SN, Reis MD, Thomas EJ. Types and origins of diagnostic errors in primary care settings. *JAMA Intern Med*. 2013;173(6):418-25. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3690001/>. Accessed July 20, 2021.

4. Liberman AL, Skillings J, Greenberg P, Newman-Toker DE, Siegal D. Breakdowns in the initial patient-provider encounter are a frequent source of diagnostic error among ischemic stroke cases included in a large medical malpractice claims database. *Diagnosis* (Berlin, Ger. 2020;7(1):37-43. <https://doi.org/10.1515/dx-2019-0031>. Accessed July 20, 2021.
5. McDonald KM, Bryce CL, Graber ML. The patient is in: patient involvement strategies for diagnostic error mitigation. *BMJ Qual Saf.* 2013;22 Suppl 2(SUPPL.2):ii33-ii39. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3786634/>. Accessed July 20, 2021.
6. Singh Ospina N, Phillips KA, Rodriguez-Gutierrez R, Castaneda-Guarderas A, Gionfriddo MR, Branda ME, Montori VM. Eliciting the patient's agenda- secondary analysis of recorded clinical encounters. *J Gen Intern Med.* 2019;34(1):36-40. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6318197/>. Accessed July 20, 2021.
7. Heyhoe J, Reynolds C, Dunning A, Johnson O, Howat A, Lawton R. Patient involvement in diagnosing cancer in primary care: a systematic review of current interventions. *Br J Gen Pract.* 2018;68(668):e211-e224. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5819987/>. Accessed July 20, 2021.
8. Tudor Car L, Papachristou N, Bull A, Majeed A, Gallagher J, El-Khatib M, Aylin P, Rudan I, Atun R, Car J, Vincent C. Clinician-identified problems and solutions for delayed diagnosis in primary care: a PRIORITIZE study. *BMC Fam Pract.* 2016;17(1):131. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5017013/>. Accessed July 20, 2021.
9. Shields CG, Epstein RM, Fiscella K, Franks P, McCann R, McCormick K, Mallinger JB. Influence of accompanied encounters on patient-centeredness with older patients. *J Am Board Fam Pract.* 2005;18(5):344-54. <https://www.jabfm.org/content/18/5/344.long>. Accessed July 20, 2021.
10. Bartels J, Rodenbach R, Ciesinski K, Gramling R, Fiscella K, Epstein R. Eloquent silences: a musical and lexical analysis of conversation between oncologists and their patients. *Patient Educ Couns.* 2016;99(10):1584-94. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6100772/>. Accessed July 20, 2021.
11. Ofri D, Trimboli O. Deep Listening: Impact Beyond Words - Why Your Doctor Needs To Listen Deeply. <https://www.oscartrimboli.com/podcast/044/>. Accessed July 20, 2021.
12. Zulman DM, Haverfield MC, Shaw JG, Brown-Johnson CG, Schwartz R, Tierney AA, Zionts DL, Safaeinili N, Fischer M, Thadaney Israni S, Asch SM, Verghese A. Practices to foster physician presence and connection with patients in the clinical encounter. *JAMA.* 2020;323(1):70-81. <https://pubmed.ncbi.nlm.nih.gov/31910284/>. Accessed July 20, 2021.
13. Graber ML. The incidence of diagnostic error in medicine. *BMJ Qual Saf.* 2013;22(SUPPL.2):ii21-ii27. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3786666/>. Accessed July 20, 2021.
14. Goss AL. How becoming a doctor made me a worse listener. *JAMA.* 2020;323(11):1041. <https://doi.org/10.1001/jama.2020.2051>. Accessed July 20, 2021.

15. Swendiman RA. Deep listening. *Acad Med*. 2014;89(6):950. <https://doi.org/10.1097/acm.000000000000238>. Accessed July 20, 2021.
16. Doyle A. Important Active Listening Skills and Techniques. <https://www.thebalancecareers.com/active-listening-skills-with-examples-2059684>. Updated November 24, 2020. Accessed July 20, 2021.
17. Giardina TD, Haskell H, Menon S, Hallisy J, Southwick FS, Sarkar U, Royse KE, Singh H. Learning from patients' experiences related to diagnostic errors is essential for progress in patient safety. *Health Aff (Millwood)*. 2018;37(11):1821-27. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8103734/>. Accessed July 20, 2021.

Patient Exit Survey

1. Sustersic M, Gauchet A, Kernou A, Gibert C, Foote A, Vermorel C, Bosson JL. A scale assessing doctor-patient communication in a context of acute conditions based on a systematic review. *PLoS One*. 2018;13(2):e0192306. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5821327/>. Accessed July 19, 2021.
2. Agency for Healthcare Research and Quality. Communication Observation Form. Content last reviewed September 2020. Agency for Healthcare Research and Quality, Rockville, MD. <https://www.ahrq.gov/health-literacy/improve/precautions/tool4c.html>.

Provider Feedback Survey

1. Sustersic M, Gauchet A, Kernou A, et al. A scale assessing doctor-patient communication in a context of acute conditions based on a systematic review. *PLoS One*. 2018;13(2):e0192306. [doi:10.1371/journal.pone.0192306](https://doi.org/10.1371/journal.pone.0192306).