**Appendix C – Safer Dx Checklist**

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| **Appendix C – Safer Dx Checklist****The Safer Dx Checklist: 10 High-Priority Practices for Diagnostic Excellence** (Scenarios are examples of actions to improve the practices) | **Ful** | **Partial** | Form ApprovedOMB No. xxxx-xxxxExp. Date xx/xx/20xx**Implementation Status** (Current state of organization’s practices)**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. | [ ]  | [ ]  | [ ]  |
| **3** | **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.** Scenario: Implement systems that allow clinicians (e.g., emergency or primary care physicians, advanced practice providers, trainees) to efficiently and reliably follow up on patients they cared for (e.g., follow up on admitted patients to learn if diagnosis changed or evolved). | [ ]  | [ ]  | [ ]  |
| **4** | **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.**Scenario: Quality and safety teams work with clinicians and non-clinical staff from various disciplines and departments to engage in safety analyses which may identify work-system/environmental factors that place a cognitive burden on clinicians. | [ ]  | [ ]  | [ ]  |
| **5** | **Health care organization actively seeks patient and family feedback to identify and understand diagnostic safety concerns and addresses concerns by codesigning solutions.** Scenario 1: Create mechanisms for patients to report diagnostic concerns and encourage and educate patients on how to report when they have concerns or sense things are not right. Scenario 2: Involve patients in root cause analyses and morbidity and mortality conferences, and engage Patient and Family Advisory Councils in codesigning solutions. | [ ]  | [ ]  | [ ]  |
| **The Safer Dx Checklist** (continued) | **Full** | **Partial** | **Not****Implemented** |
| **6** | **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.**Scenario 1: Engage patients in understanding that “no news is not necessarily good news” when it comes to test results.Scenario 2: Optimize patient review of clinician notes to encourage patients to report inaccuracies in their health records and have an organizational response plan for corrective action. | [ ]  | [ ]  | [ ]  |
| **7** | **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.**Scenario: Segment and analyze diagnostic safety data by key characteristics (e.g., race, ethnicity, gender, language, sexual orientation, gender identity) to identify inequities. | [ ]  | [ ]  | [ ]  |
| **8** | **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.**Scenario 1: Encourage regular diagnostic planning huddles or synchronous communication, such as direct face-to-face interaction or electronic group collaboration.Scenario 2: Encourage regular review of diagnostic errors jointly with diagnostic specialties and treating clinical groups, such as through interdepartmental morbidity and mortality rounds. Such activities should lead to joint ownership of improvement efforts. | [ ]  | [ ]  | [ ]  |
| **9** | **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.**Scenario: Implement evidence-based tools and resources to improve both verbal (e.g., TeamSTEPPS®) as well as electronic communication (e.g., CMS-endorsed ONC SAFER Guide for Clinician Communication). | [ ]  | [ ]  | [ ]  |
| **10** | **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.**Scenario 1: Implement evidence-based tools and resources to improve follow-up on test results, including incidental and unexpected findings (e.g., ONC SAFER Guide for Test Results Reporting and Follow-up).Scenario 2: Implement strategies to close the loop on referrals using evidence-based guidance (e.g., Closing the Loop: A Guide to Safer Ambulatory Referrals in the EHR Era). | [ ]  | [ ]  | [ ]  |
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| **Total Score****Number of “Full” responses** | **\_\_\_\_\_\_\_\_** |

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**Reference List for Additional Context**

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| **Question Number** | **Scenario Element**  | **Reference**  |
| 1 | Multidisciplinary team | Singh, Hardeep MD, MPH; Upadhyay, Divvy K. MBBS, MPH; Torretti, Dennis MD [Developing Health Care Organizations That Pursue Learning and Exploration of Diagnostic Excellence: An Action Plan, Academic Medicine](https://journals.lww.com/academicmedicine/fulltext/2020/08000/developing_health_care_organizations_that_pursue.34.aspx): August 2020 - Volume 95 - Issue 8 - p 1172-1178 doi: 10.1097/ACM.0000000000003062 |
| **3** | Systems that allow clinicians to efficiently and reliably follow up on patients they cared for | Cifra CL, Sittig DF, Singh H [Bridging the feedback gap: a sociotechnical approach to informing clinicians of patients’ subsequent clinical course and outcomes](https://qualitysafety.bmj.com/content/30/7/591): BMJ Quality & Safety 2021;30:591-597. |
| Lane, K.P., Chia, C., Lessing, J.N., Limes, J., Mathews, B., Schaefer, J., Seltz, L.B., Turner, G., Wheeler, B., Wooldridge, D. and Olson, A.P. (2019), [Improving Resident Feedback on Diagnostic Reasoning after Handovers: The LOOP Project](https://shmpublications.onlinelibrary.wiley.com/doi/abs/10.12788/jhm.3262). Journal of Hospital Medicine, 14: 622-625.  |
| **4** | Safety analysis for diagnostic errors | Reilly, James B., Myers, Jennifer S., Salvador, Doug and Trowbridge, Robert L.. "[Use of a novel, modified fishbone diagram to analyze diagnostic errors](https://doi.org/10.1515/dx-2013-0040)" Diagnosis, vol. 1, no. 2, 2014, pp. 167-171.  |
| **5** | Mechanisms for patients to report diagnostic concerns and encourage and educate patients on how to report when they have concerns or sense things are not right | Fisher KA, Smith KM, Gallagher TH, et al [We want to know: patient comfort speaking up about breakdowns in care and patient experience](file://C:\Users\monika.haugstetter\OneDrive%20-%20HHS%20Office%20of%20the%20Secretary\HomeDrive\_Contracts\__Diagnostic_Dx-Safety-%20Capacity%20Building_MedStar\OMB\Task%205%20-%20Measure%20Dx%20resource_the%20Resource\We%20want%20to%20know:%20patient%20comfort%20speaking%20up%20about%20breakdowns%20in%20care%20and%20patient%20experience) BMJ Quality & Safety 2019;28:190-197. |
| Giardina TD, Korukonda S, Shahid U, et al [Use of patient complaints to identify diagnosis-related safety concerns: a mixed-method evaluation](https://qualitysafety.bmj.com/content/30/12/996) BMJ Quality & Safety 2021;30:996-1001. |
| **6** | “No news is not necessarily good news” | Kwan JL, Cram P [Do not assume that no news is good news: test result management and communication in primary care](https://qualitysafety.bmj.com/content/24/11/664) BMJ Quality & Safety 2015;24:664-666. |
| Encourage patients to report inaccuracies in their health records and have an organizational response plan for corrective action | Bell SK, Delbanco T, Elmore JG, et al. [Frequency and Types of Patient-Reported Errors in Electronic Health Record Ambulatory Care Notes](https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2766834). JAMA Netw Open. 2020;3(6):e205867. doi:10.1001/jamanetworkopen.2020.5867 |
| **8** | Regular diagnostic planning huddles or synchronous communication, such as direct face-to-face interaction or electronic group collaboration | Singh H, Zwaan L. Annals for Hospitalists Inpatient Notes - [Reducing Diagnostic Error-A New Horizon of Opportunities for Hospital Medicine](https://www.acpjournals.org/doi/10.7326/M16-2042). Ann Intern Med. 2016;165(8):HO2-HO4. doi:10.7326/M16-2042 |
| Klobuka AJ, Lee J, Buranosky R, et al. [When the Reading Room Meets the Team Room: Resident Perspectives From Radiology and Internal Medicine on the Effect of Personal Communication After Implementing a Resident-Led Radiology Rounds](https://www.sciencedirect.com/science/article/abs/pii/S0363018817302591). Curr Probl Diagn Radiol. 2019;48(4):312-322. doi:10.1067/j.cpradiol.2018.02.005 |
| **9** | TeamSTEPPS® | <https://www.ahrq.gov/teamstepps/index.html> |
| ONC SAFER Guide for Clinician Communication | [https://www.healthit.gov/sites/default/files/safer/guides/safer](https://www.healthit.gov/sites/default/files/safer/guides/safer_clinician_communication.pdf)[\_clinician\_communication.pdf](https://www.healthit.gov/sites/default/files/safer/guides/safer_clinician_communication.pdf) |
| **10** | Evidence-based tools and resources to improve follow-up on test results | <https://www.jointcommission.org/resources/news-and-multimedia/newsletters/newsletters/quick-safety/quick-safety-issue-52/#.YoO1zoXMI2x> |
| ONC SAFER Guide for Test Results Reporting and Follow-up | [https://www.healthit.gov/sites/default/files/safer\_test\_](https://www.healthit.gov/sites/default/files/safer_test_results_reporting.pdf)[results\_reporting.pdf](https://www.healthit.gov/sites/default/files/safer_test_results_reporting.pdf) |
| Closing the Loop: A Guide to Safer Ambulatory Referrals in the EHR Era | Institute for Healthcare Improvement / National Patient Safety Foundation. [Closing the Loop: A Guide to Safer Ambulatory Referrals in the EHR Era](http://www.ihi.org/resources/Pages/Publications/Closing-the-Loop-A-Guide-to-Safer-Ambulatory-Referrals.aspx). Cambridge, Massachusetts: Institute for Healthcare Improvement; 2017 |

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