

## **Appendix C – Safer Dx Checklist**

## Appendix C Safer Dx Checklist

Form Approved  
 OMB No. XXXX-XXXX  
 Exp. Date xx/xx/20xx

**Implementation Status**  
 (Current state of  
 organization's practices)

Not  
 Implemented

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

(Scenarios are examples of actions to improve the practices)

		Ful	Partial	
1	<b>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.</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	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	<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.</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	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	<b>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.</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	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	<b>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.</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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	<b>Health care organization actively seeks patient and family feedback to identify and understand diagnostic safety concerns and addresses concerns by codesigning solutions.</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	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	<b>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.</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	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	<b>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.</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Scenario: Segment and analyze diagnostic safety data by key characteristics (e.g., race, ethnicity, gender, language, sexual orientation, gender identity) to identify inequities.			

8	<b>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.</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	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	<b>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.</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Scenario: Implement evidence-based tools and resources to improve both verbal (e.g., TeamSTEPS®) as well as electronic communication			

(e.g., CMS-endorsed ONC SAFER Guide for Clinician Communication).

**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.**

  

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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).

## Total Score

Number of "Full" responses \_\_\_\_\_

### Reference List for Additional Context

Question Number	Scenario Element	Reference
1	Multidisciplinary team	Singh, Hardeep MD, MPH; Upadhyay, Divvy K. MBBS, MPH; Torretti, Dennis MD <a href="#">Developing Health Care Organizations That Pursue Learning and Exploration of Diagnostic Excellence: An Action Plan</a> , <i>Academic Medicine</i> : 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 <a href="#">Bridging the feedback gap: a sociotechnical approach to informing clinicians of patients' subsequent clinical course and outcomes</a> : <i>BMJ Quality &amp; Safety</i> 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), <a href="#">Improving Resident Feedback on Diagnostic Reasoning after Handovers: The LOOP Project</a> . <i>Journal of Hospital Medicine</i> , 14: 622-625.
4	Safety analysis for diagnostic errors	Reilly, James B., Myers, Jennifer S., Salvador, Doug and Trowbridge, Robert L.. " <a href="#">Use of a novel, modified fishbone diagram to analyze diagnostic errors</a> " <i>Diagnosis</i> , 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 <a href="#">We want to know: patient comfort speaking up about breakdowns in care and patient experience</a> <i>BMJ Quality &amp; Safety</i> 2019;28:190-197.
		Giardina TD, Korukonda S, Shahid U, et al <a href="#">Use of patient complaints to identify diagnosis-related safety concerns: a mixed-method evaluation</a> <i>BMJ Quality &amp; Safety</i> 2021;30:996-1001.
6	"No news is not necessarily good news"	Kwan JL, Cram P <a href="#">Do not assume that no news is good news: test result management and communication in primary care</a> <i>BMJ Quality &amp; Safety</i> 2015;24:664-666.
	Encourage patients to report	Bell SK, Delbanco T, Elmore JG, et al. <a href="#">Frequency and Types of</a>

	inaccuracies in their health records and have an organizational response plan for corrective action	<a href="#">Patient-Reported Errors in Electronic Health Record Ambulatory Care Notes</a> . 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 - <a href="#">Reducing Diagnostic Error-A New Horizon of Opportunities for Hospital Medicine</a> . Ann Intern Med. 2016;165(8):HO2-HO4. doi:10.7326/M16-2042
		Klobuka AJ, Lee J, Buranosky R, et al. <a href="#">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</a> . Curr Probl Diagn Radiol. 2019;48(4):312-322. doi:10.1067/j.cpradiol.2018.02.005
9	TeamSTEPPS®	<a href="https://www.ahrq.gov/teamstepps/index.html">https://www.ahrq.gov/teamstepps/index.html</a>
	ONC SAFER Guide for Clinician Communication	<a href="https://www.healthit.gov/sites/default/files/safer/guides/safer_clinician_communication.pdf">https://www.healthit.gov/sites/default/files/safer/guides/safer_clinician_communication.pdf</a>
10	Evidence-based tools and resources to improve follow-up on test results	<a href="https://www.jointcommission.org/resources/news-and-multimedia/newsletters/newsletters/quick-safety/quick-safety-issue-52/#.YoO1zoXMI2x">https://www.jointcommission.org/resources/news-and-multimedia/newsletters/newsletters/quick-safety/quick-safety-issue-52/#.YoO1zoXMI2x</a>
	ONC SAFER Guide for Test Results Reporting and Follow-up	<a href="https://www.healthit.gov/sites/default/files/safer_test_results_reporting.pdf">https://www.healthit.gov/sites/default/files/safer_test_results_reporting.pdf</a>
	Closing the Loop: A Guide to Safer Ambulatory Referrals in the EHR Era	Institute for Healthcare Improvement / National Patient Safety Foundation. <a href="#">Closing the Loop: A Guide to Safer Ambulatory Referrals in the EHR Era</a> . Cambridge, Massachusetts: Institute for Healthcare Improvement; 2017

This survey is authorized under 42 U.S.C. 299a. 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 25 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. 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.