

## **Attachment C: Safer Dx Checklist**

Please complete the following organizational self-assessment; it should take no longer than 15 minutes to complete.

For each of the 10 checklist items, team members from the organization (either individually or as a group) should select the **Implementation Status** that best represents the current state of their organization's practices:

- **Full:** A well-known and well-documented practice that occurs reliably in the organization.
- **Partial:** The practice occurs in the organization sometimes. While it is well-documented, the practice is not well known or it may be implemented inconsistently across the organization.
- **Not Implemented:** This practice does not occur in the organization.

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 15 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](mailto:MEPSPROJECTDIRECTOR@ahrq.hhs.gov).

## 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

		Full	Partial	Not Implemented
1	<p><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></p> <p>Scenario 1: Senior leadership/C-suite establish a multidisciplinary <a href="#">team</a> (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.</p> <p>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.</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	<p><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></p> <p>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.</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	<p><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></p> <p>Scenario: Implement <a href="#">systems</a> that allow clinicians (e.g., emergency or primary care physicians, advanced practice providers, trainees) to efficiently and <a href="#">reliably follow up</a> on patients they cared for (e.g., follow up on admitted patients to learn if diagnosis changed or evolved).</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	<p><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></p> <p>Scenario: Quality and safety teams work with clinicians and non-clinical staff from various disciplines and departments to engage in <a href="#">safety analyses</a>, which may identify work-system/environmental factors that place a cognitive burden on clinicians.</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	<p><b>Health care organization actively seeks patient and family feedback to identify and understand diagnostic safety concerns and addresses concerns by codesigning solutions.</b></p> <p>Scenario 1: Create <a href="#">mechanisms</a> for patients to report <a href="#">diagnostic concerns</a> and encourage and educate patients on how to report when they have concerns or sense things are not right.</p> <p>Scenario 2: Involve patients in root cause analyses and morbidity and mortality conferences, and engage Patient and Family Advisory Councils in codesigning solutions.</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

The Safer Dx Checklist (continued)		Full	Partial	Not Implemented
6	<p><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></p> <p>Scenario 1: Engage patients in understanding that <a href="#">“no news is not necessarily good news”</a> when it comes to test results.</p> <p>Scenario 2: Optimize patient review of clinician notes to encourage patients to report <a href="#">inaccuracies</a> in their health records and have an organizational response plan for corrective action.</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	<p><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></p> <p>Scenario: Segment and analyze diagnostic safety data by key characteristics (e.g., race, ethnicity, gender, language, sexual orientation, gender identity) to identify inequities.</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8	<p><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></p> <p>Scenario 1: Encourage regular diagnostic planning huddles or <a href="#">synchronous communication</a>, such as direct face-to-face <a href="#">interaction</a> or electronic group collaboration.</p> <p>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.</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9	<p><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></p> <p>Scenario: Implement evidence-based tools and resources to improve both verbal (e.g., <a href="#">TeamSTEPPS®</a>) as well as electronic communication (e.g., CMS-endorsed <a href="#">ONC SAFER Guide for Clinician Communication</a>).</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10	<p><b>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.</b></p> <p>Scenario 1: Implement evidence-based tools and resources to improve follow-up on <a href="#">test results</a>, including incidental and unexpected findings (e.g., <a href="#">ONC SAFER Guide for Test Results Reporting and Follow-up</a>).</p> <p>Scenario 2: Implement strategies to close the loop on referrals using evidence-based guidance (e.g., <a href="#">Closing the Loop: A Guide to Safer Ambulatory Referrals in the EHR Era</a>).</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### Total Score

Number of “Full” responses

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THE DIGITAL VERSION OF THIS CHECKLIST INCLUDES HYPERLINKED RESOURCES THAT SHOULD BE REVIEWED TO SUPPLEMENT PRIORITY PRACTICES AND SCENARIOS

