The Safer Dx Checklist

10 High-Priority Organizational Practices for Diagnostic Excellence

PREPARED BY:

Center for Innovation in Quality, Effectiveness, and Safety (IQuESt), Michael E. DeBakey Veterans Affairs Medical Center and Baylor College of Medicine, Houston, TX

- Hardeep Singh, MD, MPH (Principal Investigator)
- Abigail Marinez, MPH
- Umair Mushtaq, MBBS, MS
- Umber Shahid, PhD, MPH

Geisinger, Danville, PA

- Divvy Kant Upadhyay, MD, MPH

Institute for Healthcare Improvement, Boston, MA

- Joellen Huebner, BA
- Patricia McGaffigan, RN, MS, CPPS

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Subject Matter Experts

Bimal R. Desai, MD, MBI, Children's Hospital of Philadelphia and University of Pennsylvania

Robert El-Kareh, MD, MPH, MS, University of California San Diego

Patricia H. Folcarelli, RN, MA, PhD, CRICO and Harvard Medical School

Tejal Gandhi, MD, MPH, CPPS, Press Ganey Associates, LLC

Christine Goeschel, ScD, MPA, MPS, RN, FAAN, MedStar Institute for Quality and Safety and Georgetown University

Helen Haskell, MA, Mothers Against Medical Error

Yael Heher, MD, MPH, FRCP(C), Massachusetts General Hospital

Prashant Mahajan, MD, MPH, MBA, University of Michigan

Dennis Torretti, MD, Geisinger Medical Center

Mike Woodruff, MD, Intermountain Healthcare

Field Test Reviewers

Rahul K. Shah, MD, MBA, Children's National Hospital

Jeffrey Salvon-Harman, MD, Presbyterian Healthcare Services

Mona Krouss, MD, FACP, CPPS, NYC Health + Hospitals

Correspondence to: *Dr. Hardeep Singh*
Email: hardeeps@bcm.edu
Twitter: @HardeepSinghMD
Dr. Singh's PubMedLink

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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, reviews of existing literature and reports, a Delphi consensus expert panel to narrow the list of practices, an expert panel to finalize the top 10 practices, and a field test with users.

The assessment should inform an improvement plan with clear action steps, roles and responsibilities, and metrics to gauge progress. The senior leader/champion should periodically discuss checklist results with organizational leaders and the governing board to engage them in diagnostic safety improvement efforts. Several scenarios and illustrative examples of actions are provided.

Checklist Responses

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.

Interpreting Checklist Results

Count checklist items with "Full" responses to identify where you are in your journey to diagnostic excellence. Items "Not Implemented" are critical opportunities for improvement.

- **Beginning:** 0 to 3 "Full" responses
- **Making progress:** 4 to 6 "Full" responses
- **Exemplar:** 7 or more "Full" responses

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 representatives, medical educators, and trainees. This team should meet regularly to review and analyze the current state of diagnostic safety and work toward implementation of all 10 checklist items.
3. **Complete the checklist** as a team or independently. If independent review is preferred, team members should discuss responses and come to consensus on next steps.
4. **Develop an action plan** that includes clear next steps, metrics of progress, and roles and responsibilities to oversee implementation. The plan needs to be supported by the senior leader champion.
5. **Identify regular checkpoints for follow up** that include annual review of the checklist and periodic monitoring and revisions to the action plan.

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(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.	☐	☐	☐
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).	☐	☐	☐

Total Score
Number of "Full" responses _____

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