CAI Resource Guide for the Webinar:

Two Sides of the Coin: A Patient/Provider Dyad Explore Diagnostic Error and the Benefits of CRP

The Best Practices Committee for the Collaborative for Accountability and Improvement curated the following list of publications, tools, and resources to complement and enhance the learning from the webinar on *Two Sides of the Coin: A Patient/Provider Dyad Explore Diagnostic Error and the Benefits of CRP.*

Webinar Learning Objectices

- Understand the individual and system factors that can cause diagnostic errors
- Explore the benefits of a CRP response following a diagnostic error
- Examine the consequences of a poor response to a diagnostic error
- Understand the importance of engaging, listening, and learning from patients and families following diagnostic errors

WHO WILL BENEFIT

- Health care executives and leadership
- Risk managers
- Claims staff
- Patient safety and quality improvement staff
- Clinicians
- Patient and family advocates

PRESENTERS

- Suz Schrandt, JD, Founder, CEO, & Chief Patient Advocate at ExPPect
- Eric J. Thomas, MD, MPH Associate Dean for Healthcare Quality, McGovern Medical School, University of Texas Health Science Center at Houston; Board President, Collaborative for Accountability and Improvement

WATCH THE WEBINAR ON THE CAI YOUTUBE CHANNEL

http://bit.ly/thecaiyoutube

Publications

BOOK TITLE

Improving Diagnosis in Health Care

AUTHORS

Committee on Diagnostic Error in Health Care; Erin P. Balogh, Bryan T. Miller, and John R. Ball, Editors; Board on Health Care Services; Institute of Medicine; The National Academies of Sciences, Engineering, and Medicine

BOOK SUMMARY

The Committee on Diagnostic Error's recommendations in this publication address eight goals to improve diagnosis and reduce diagnostic error:

- **Goal 1:** Facilitate more effective teamwork in the diagnostic process among health care professionals, patients, and their families

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ARTICLE SUMMARY(CONT.)

- **Goal 2**: Enhance health care professional education and training in the diagnostic process
- **Goal 3:** Ensure that health information technologies support patients and health care professionals in the diagnostic process
- **Goal 4:** Develop and deploy approaches to identify, learn from, and reduce diagnostic errors and near misses in clinical practice
- **Goal 5:** Establish a work system and culture that supports the diagnostic process and improvements in diagnostic performance
- **Goal 6:** Develop a reporting environment and medical liability system that facilitates improved diagnosis by learning from diagnostic errors and near misses
- **Goal 7:** Design a payment and care delivery environment that supports the diagnostic process
- **Goal 8:** Provide dedicated funding for research on the diagnostic process and diagnostic errors

For a complete summary of the framework for reducing diagnostic error and improving diagnosis, and the committee's recommendations for all diagnostic team members and setting of care, see pages 1 - 18 of this book.

READ THE BOOK AT

https://www.ncbi.nlm.nih.gov/books/NBK338596/pdf/Bookshelf_NBK338596.pdf

REPORT TITLE

The Power to Predict: Leveraging Medical Malpractice Data to Reduce Patient Harm and Financial Loss

AUTHORS

CRICO Strategies

REPORT SUMMARY

- CRICO analyzed 37,000 medical professional liability (MPL) cases closed between 2014 and 2018 to determine which breakdowns in the healthcare process indicate the highest odds of an asserted claim or lawsuit closing with a payment.
- The analysis identified three key characteristics that, when present, most significantly increase the odds that a given MPL cases will close with an indemnity payment:
  - Failure to have or follow a policy or protocol
  - Patient assessment failures
  - Absent or insufficient documentation
- Contributing factors denote breakdowns in technical skills, clinical judgement, communications, behavior, systems, environment, equipment, and teamwork. The majority are relevant across clinical specialties, settings, and disciplines.
- Read more about each of these contributing factors and sample cases in the full report, and learn how using the power to predict may assist organizations in addressing opportunities for improvement.

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READ THE REPORT AT

https://www.rmf.harvard.edu/Malpractice-Data/Annual-Benchmark-Reports/The-Power-to-Predict

REPORT TITLE

Malpractice Risks in the Diagnostic Process

AUTHORS

CRICO Strategies

REPORT SUMMARY

The 2014 report examines more than 4,700 diagnosis-related malpractice cases that demonstrate the pitfalls that put patients at risk of a missed or significantly delayed diagnosis. It addresses where in the clinician's thought process mistakes are most likely to occur and furthers the discussion on changes necessary to prevent them.

- While a single case has multiple contributing factors to an error in diagnosis, more than 82% have been mapped to one of three broad steps in CRICO's diagnostic process care framework:
  - Initial diagnosis assessment
  - Testing and results processing
  - Communication and coordination of follow-up
- The analysis found that over half of the cases reviewed reflect a missed opportunity early in the diagnostic process. This is when the risk of missed or delayed diagnosis is highest: when the physician must rely on instinct of which tests should be ordered.
- Take a look at this report to dive a bit deeper into causes of diagnostic errors and learn about effective solutions to the cognitive and systemic problems that can impede prompt and accurate diagnoses.

READ THE REPORT AT

https://www.rmf.harvard.edu/Malpractice-Data/Annual-Benchmark-Reports/Risks-in-the-Diagnostic-Process

ARTICLE TITLE

What If?: Transforming Diagnostic Research by Leveraging a Diagnostic Process Map to Engage Patients in Learning from Errors

AUTHORS

Sue Sheridan, Patricia Merryweather, Diana Rusz, and Gordon Schiff

ARTICLE SUMMARY

Patients and family members with lived experiences of diagnostic error have unique perspectives with which to view the process of diagnosis—a perspective that has historically not been considered during the conceptualization or development of diagnostic research projects.

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ARTICLE SUMMARY (CONT.)

This article explains the method for diagramming diagnostic error against the NAM diagnostic process map to help drill down into what actually 'broke' during the diagnostic process and what solutions we can collectively build.

This project helped advance diagnostic researchers to understand the importance of engaging patients in research. It also led to the development of innovative curriculum to educate patients in research methodology, including providing patients and family members with the knowledge, skills, and tools to effectively partner with researchers in the design, execution, and dissemination of diagnostic patient-centered outcomes research and comparative effectiveness research. Learn more about this important work in the article.

READ THE ARTICLE AT

https://doi.org/10.31478/202002a

Tools and Resources

RESOURCE NAME

Patient's Toolkit for Diagnosis

ORGANIZATION

Society to Improve Diagnosis in Medicine (SIDM)

HOW TO USE THIS TOOLKIT

Having patients actively engaged in their care helps healthcare professionals develop more accurate, timely diagnoses. To help encourage this engagement, SIDM has developed the Patient's Toolkit, **a resource for patients, by patients**.

- SIDM's toolkit was designed for patients visiting their healthcare provider to help tell their story clearly.
- Preparing ahead of time for medical appointments allows patients to think about concerns, symptoms, and other important information that healthcare professionals will need, and what they want to get out of the conversation during their visit.
- Patients can follow a set of prompts and questions posed in the toolkit to help encourage participation and partnership with medical professionals.
- The Patient's Toolkit is available in both English and Spanish.

DOWNLOAD THE TOOLKIT AT

https://www.improvediagnosis.org/patients-toolkit/

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The Collaborative for Accountablity and Improvement

CONTACT INFORMATION

For more information on these topics, please contact thecai@uw.edu or visit the CAI Website at http://communicationandresolution.org/

FOR ADDITIONAL CRP TOOLS AND RESOURCES

- For CRP Implementation focused tools and resources, visit http://communicationandresolution.org/topics/crp-implementation/?submit=Filter
- For general CRP tools and resources, visit CAI Resource Library at http://communicationandresolution.org/resources/

FOR MORE CRP WEBINARS

Visit the CAI YouTube Channel at http://bit.ly/thecaiyoutube

Resource guide late updated April 15, 2021

Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT
Reaching resolution after patient harm