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Health System Level Initiatives to Improve Diagnosis

No conflicts of interest to report

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and AHRQ National Advisory Council

Perspective:

CVD is our nation's costliest and most devastating chronic disease, and is fraught with errors in diagnosis and treatment, (particularly among women).

1 ***CVD is our nation's costliest and most devastating chronic disease, and is fraught with errors in diagnosis and treatment, particularly among women.*** Nearly $320 billion in annual healthcare costs and lost productivity are attributable to CVD.[5] Annual direct medical costs related to CVD are predicted to reach $818 billion by 2030, with lost productivity costs approaching $220 billion.[5] CVD is the leading cause of morbidity and mortality, responsible for about 25% of all deaths.[39] Despite significant evidence regarding risk factors, effective therapeutic interventions, and raised public awareness[7,21,40], nearly half of all women do not recognize heart disease as their number one killer.[39] A study of CVD claims in ambulatory care reported primary allegations of: diagnostic error (75%), involving errors in clinical judgment (81%), failure or delay in ordering a diagnostic test including lack of referral (41%), and failure to establish a differential diagnosis (33%).[41] Moreover, a recent survey published in the Journal of the American of Cardiology reported that only 22% of primary care physicians and 42% of cardiologists felt well prepared to assess women's CVD risk.[40]

Perspective

Health System Initiatives are critical to Improve Diagnosis

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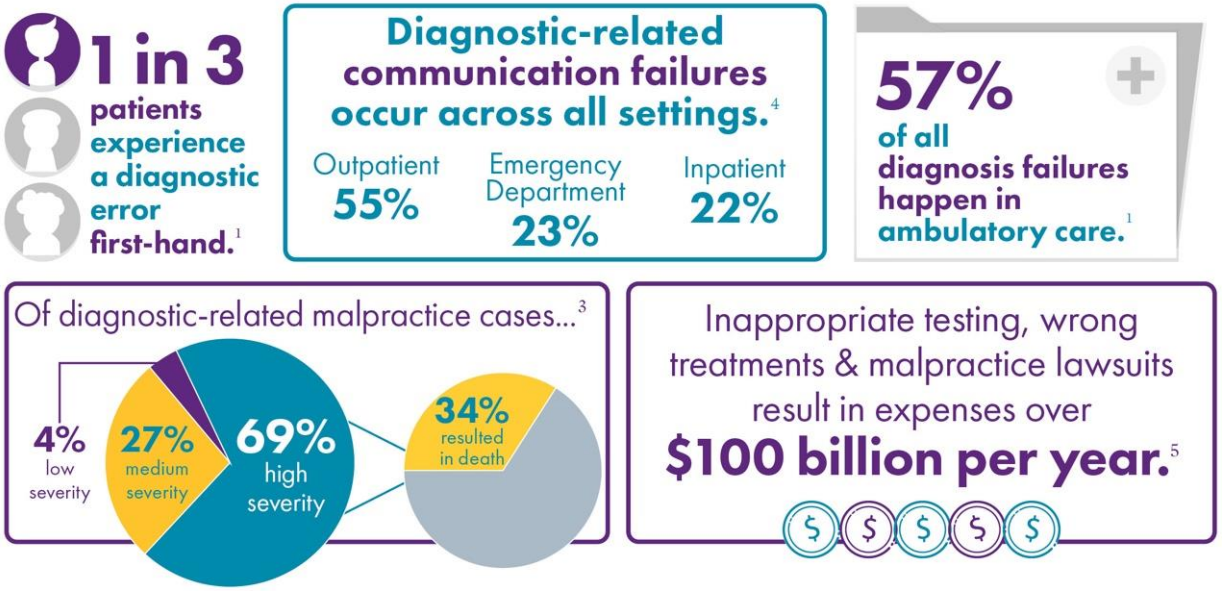

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Organizational readiness

- Align with existing quality and safety improvement work

Start small, start where you are

Engaging clinical leaders to support diagnostic safety measurement

What is important to clinical leaders?

- Patient safety & clinical outcomes
- Evidence to support change
- Measurement for learning
- Efficiency and effectiveness

Start small, start where you are

What is important to administrative leaders?

- Patient safety & clinical outcomes
- Regulatory compliance
- Pay for performance
- Associate safety and health
- Community collaborations

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Start small, start where you are

Opportunities and Challenges…

- Measurement is **absolutely** necessary, but not sufficient…
- A deliberate and explicit approach to measurement with clear intent and purpose should help accelerate improvement.

Measurement Starts with a Definition…

- Several used in literature but picking one that suits you is essential

- NASEM defined diagnostic error as:
  - "failure to establish an *accurate and timely* explanation of the patient's health problem(s) or
  - *communicate* that explanation to the patient."

National Academies of Sciences, Engineering, and Medicine. *Improving Diagnosis in Health Care;* 2020

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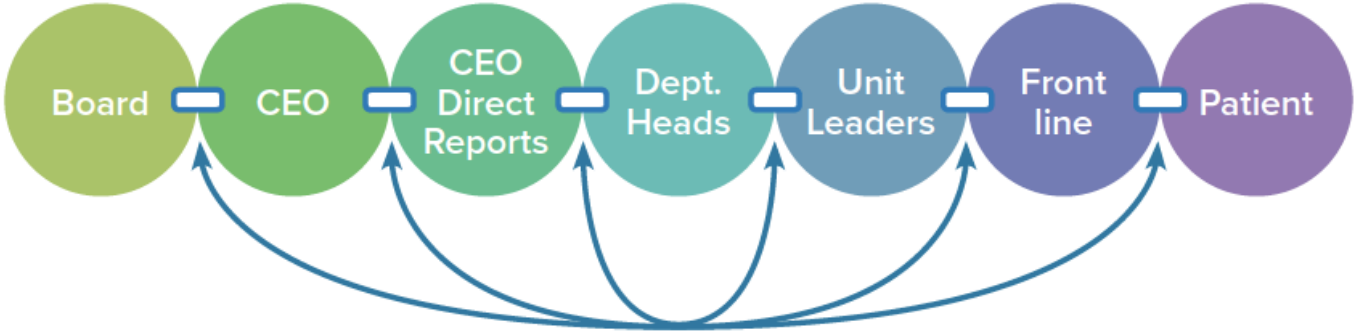
…and a Purpose

- Learning and improvement
- Research
- Accountability and benchmarking

Evolving Model of Accountability



Accountability & Feedback	*Capacity*	*Time and Resources*
Set the stage with clear expectations, ongoing feedback, and fair consequences for failure and success.	All organizational members are equipped with the knowledge, skills, and attitudes necessary for supporting, developing, and enacting safety appropriate to their role in the organization.	Equip your staff by providing the bandwidth and tools they need to get the job done.

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Start small, start where you are

Detecting Missed Opportunities in Diagnosis

- Data sources
  - Routinely collected quality and safety events
  - Clinician reports
  - Patient reports
  - Administrative databases
  - Medical records/EHRs

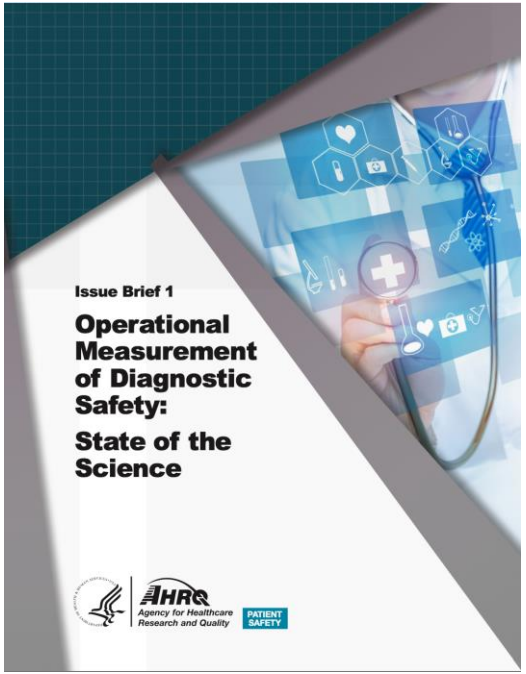

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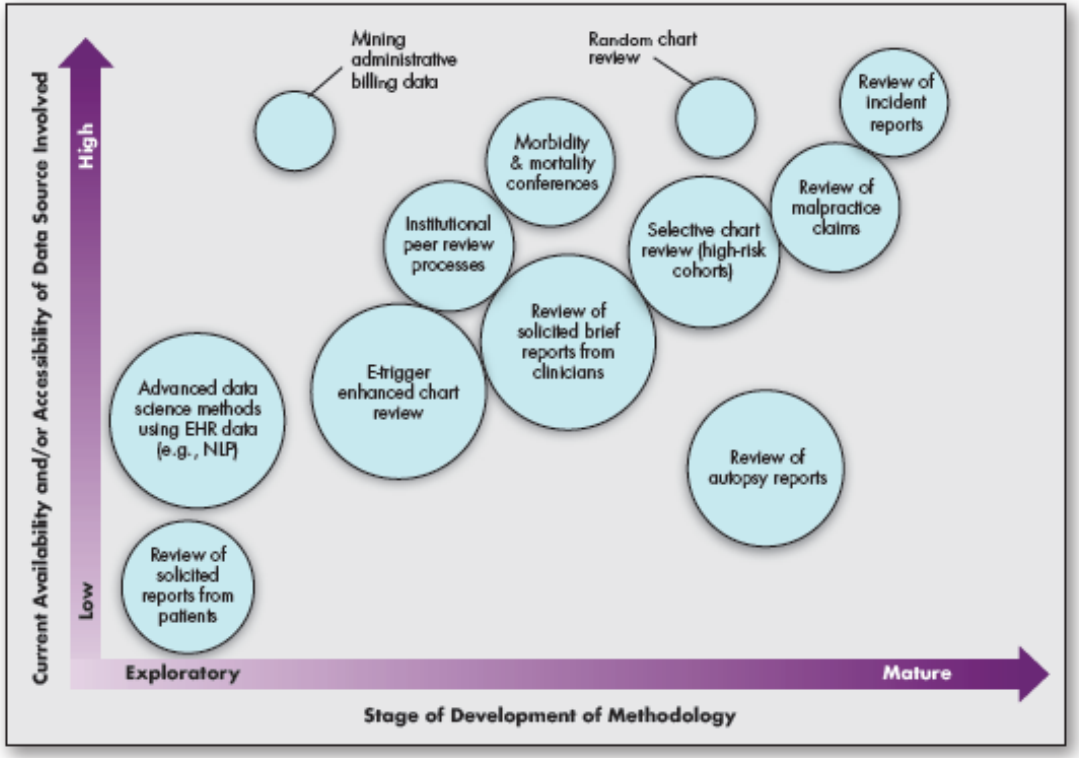
Figure 2. Implementation Readiness of Diagnostic Safety Measurement Strategies



Note: Larger circles denote higher potential yield for cases that can inform systemwide learning and improvement. Measurement strategies that are ready for implementation balance validity and yield (i.e., an estimate of the proportion of cases with diagnostic errors that could lead to learning and improvement relative to measurement effort). The relative position of these methods will vary according to local context; Figure 2 illustrates data sources for a typical healthcare organization equipped with an EHR and moderate resources for quality and safety improvement.

Start Small, Start Where You Are

Start NOW

Thank you

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