The Role of PFE in Improving Diagnosis in Medicine

Hospital Improvement Innovation Network (HIIN) PFE Learning Event

February 14, 2019
Welcome and Roll Call

Welcome back!

Who is in the room?

Tom Workman, PhD
Senior Advisor, PFEC
A Framework for Today

The Role of PFE in Improving Diagnosis in Medicine
• Tom Workman

Partnering with Patients & Families for Improved Diagnosis: “What ifs”
• Sue Sheridan, Director, Patient Engagement, Society to Improve Diagnosis in Medicine (SIDM)

HRET Change Package: “Improving Diagnosis in Medicine”
• Lydie Marc, Program Manager and Performance Improvement Coach, HRET HIIN

Discussion
• Everyone!

Moving Forward in Action
• Tom Workman
The PFE Metrics and Diagnostic Errors

PFE Metric 1: Preadmission Planning Checklist
• Tailor the checklist to invite patients and families to be partners in the diagnostic process

PFE Metric 2: Shift Change Huddles or Bedside Reporting
• Invite patients and families to share and correct/confirm information and ask questions to help prevent diagnostic errors

PFE Metric 3: Dedicated PFE Leader
• Educate leaders, clinicians, and staff about the benefits of partnering with patients and families to help reduce diagnostic errors

PFE Metric 4 (PFAC or Representative(s) on Hospital Committee) and PFE Metric 5 (Patient Representative on Board of Directors)
• Provide orientation and training to patient and families on diagnostic safety to prepare them to partner with leaders, clinicians, and staff
Partnering with Patients for Improved Diagnosis

“What Ifs”

Susan Sheridan, MIM, MBA, DHL
Director, Patient Engagement
Society to Improve Diagnosis in Medicine (SIDM)
Impact of Diagnostic Error
National Academy of Medicine (NAM)

- Diagnostic errors affect more than 12 million adults in outpatient settings each year.
- 40,000-80,000 die each year from diagnostic failures in U.S. hospitals alone.
- Every 9 minutes someone in a US hospital dies due to a medical diagnosis that was wrong or delayed.
NAM definition: What is a Diagnostic Error?

The failure to:
(a) establish an accurate and timely explanation of the patient’s health problem(s)

or
(b) communicate that explanation to the patient
ECRI: DxE is #1 Patient Safety Concern (March 2018)

Executive Brief

Top 10 Patient Safety Concerns
for Healthcare Organizations
2018

Diagnostic Errors

According to both studies and claims analyses, diagnostic errors are common, and they can have serious consequences. Miscommunication is a common issue, but often not the only one. “It’s a multifactorial problem,” says Gail M. Horvath, MSN, RN, CNOR, CRCST, patient safety analyst and consultant, ECRI Institute. “Diagnostic errors are the result of cognitive, systemic, or a combination of cognitive and systemic factors.”

Diagnostic errors are also challenging to measure and learn from because they often go undetected until after the patient leaves the hospital or emergency department (ED). Healthcare organizations should capture data on diagnostic errors and near misses. Sources may include the event-reporting system, malpractice and payment claims, patient complaints, patient surveys, autopsies, and record reviews. The organization can then make changes to address gaps. Discussing the topic in multiple forums, such as grand rounds and debriefings, can support ongoing analysis and learning for clinicians.

Adapted from Top 10 Patient Safety Concerns for Healthcare Organizations 2018. ECRI Institute | www.ecri.org. ECRI Institute encourages the dissemination of this information in print or electronic form without fee for non-commercial purposes. This work may not be used for commercial purposes or for direct or indirect self-promotion. No warranties are expressed or implied. © 2018 ECRI Institute. All rights reserved.
National Academy of Medicine’s Diagnostic Process

**THE WORK SYSTEM**
- Diagnostic Team Members
- Tasks
- Technologies and Tools
- Organization
- Physical Environment
- External Environment

**THE DIAGNOSTIC PROCESS**

**Communication of the Diagnosis**
The explanation of the health problem that is communicated to the patient

**Treatment**
The planned path of care based on the diagnosis

**Outcomes**

**TIME**

*The National Academies of
SCIENCES • ENGINEERING • MEDICINE*

Case Study - Pat Sheridan:
Failure to communicate a malignant pathology
Pat’s Diagnostic Journey

Pat has severe neck pain. Seeks Dr. appt. in Idaho

Pat and Sue unaware of fragmented healthcare system. Assumes coordination and communication between all involved.

MRI – Idaho
Mass in cervical spine
Referred to Neurosurgeon in Arizona

Surgery/Pathology-Arizona
“Atypical spindle cell neoplasm
Final diagnosis pending”

“Consistent with benign Schwannoma”

Final Pathology (23 days later):
Malignant spindle cell neoplasm
Failed to get communicated to Neurosurgeon, referring doctor or Pat and Sue

“Benign tumor.”
Follow up with referring doctor in Idaho for removal of stitches

6 month delay in diagnosis.
Tumor penetrated spinal cord.
After 5 more surgeries, chemo and radiation Pat died on March 8, 2002

The Work System
Factors contributing to Pat’s diagnostic error

- Policies and procedures
- Support from central function
- Training and education
- Scheduling and bed management
- Lines of responsibility
- Staff workload
- Supervision and leadership
- Management of staff and staffing levels
- Equipment and materials
- Patient factors
- Team factors
- Individual factors
- Task characteristics
- Communications systems
- Safety culture
- External factors

Rebecca Lawton,1 Rosemary R C McEachan,2 Sally J Giles,2 Reema Sirriyeh,1 Ian S Watt,3 John Wright2 BMJ Qual Saf 2012;21:369e380. doi:10.1136/bmjqs-2011-000443
• The pathologist had been part of the “diagnostic team” and played a central role in the diagnostic process and had 2 way communication with the treating clinicians? (Remove the “wall” separating pathologists from treating clinicians)

• The referring physician and I had access to electronic health records (EHRs), including real time clinical notes and diagnostic testing results, to enable us to participate in the diagnostic process and review the health records for accuracy?
“What If”

- Patients and family members were part of the diagnostic team?

- Patients and family members were embedded in the infrastructure of your organization as partners in governance, policy and diagnostic improvement efforts?
What if:
HRET Diagnostic Error Change Package: *Improving Diagnosis in Medicine*

Lydie Marc, MPH, CHES
Program Manager and Performance Improvement Coach
AHA Center for Health Innovation
Engaging Patients in Reducing Diagnostic Error

- Patient
- Health care team
- Family
- Health care system
- PFAC
Diagnostic Error Change Package

- Measurement
- Best Practices
- Case Studies
- Tools and Resources
Core Elements of Successful Diagnostic Error Programs Include:

- Leadership Commitment
- Accountability
- Action
- Evaluation
- Communication
Examples from the field:

- Kaiser Permanente SureNet Program
  - The KP SureNet connects with more than 100,000 patients per year.
  - Under the program, more than 50 initiatives are aimed at diagnosis detection to identify lapses in care and intervene before a patient is affected.
  - A key lesson learned is that developing and maintaining a centralized process to systematically follow patients is an effective method to ensure appropriate and timely care is provided.
Examples from the field:

- **The MedStar Health Sepsis Collaborative**
  - Began two and a half years ago with a small team, including senior leaders and a patient advocate from the health system’s Patient and Family Advisory Council for Quality and Safety.
  - This initiative focused on organizational quality improvement, such as attaining new skills and implementing new processes via a standard improvement structure, awareness, and care outcomes.
  - Between October 2016 and October 2017, MedStar’s rate of compliance with national standards for sepsis treatment improved by 23%.
How do I use this tool?

**Self-Assessment**
- Concern or barriers
- Strategies to overcome the barrier

**Champions**
- Role
- How might this role support your efforts to improve performance?
- When and how will you engage this role?

**Resource Needs**
- When and how will you get this resource?
- How can my organization support this need?

**Action Plan**
- How will this happen?
- Who will make this happen?
- How do I know to move to next step and by when?
- What could stand in the way of success and how will I address it?

Diagnostic Error Change Package
Top Ten Checklist

1. Provide and promote patient access to electronic health records (EHRs), optimally including real-time clinical notes and diagnostic testing results.
2. Evaluate patient and family engagement practices, organizational structure, clinical operations, and access to care, including patient access to EHRs, to support the diagnostic environment and diagnostic process.
3. Implement clinical decision support tools that improve cognitive performance and reflective self-practice.
4. Provide regular education and training on clinical reasoning and decision pitfalls.
5. Establish a learning environment, inclusive of patients and family members, with an infrastructure based on safety culture, transparency, quality improvement, and education.
6. Measure and report diagnostic errors regularly for greater transparency and visibility.
7. Provide orientation and training on diagnostic safety and quality to support patient and family participation in governance, including on patient and family advisory councils, practice improvement teams, and boards.
8. Provide tools and credible resources for patients and family members and use engagement methods to optimize participation in the diagnostic process. Tools and methods include Society to Improve Diagnostics in Medicine tools, shared decision making, teach-back, patient activation strategies (PAM), and discharge checklists.
9. Adapt the Partnership for Patients preadmission checklist to orient patients to the diagnostic process, which effectively invites them to participate in the process.
10. Develop systems for tracking and studying diagnostic errors, including using the diagnostic error fishbone diagram for root cause analysis.

Tasks for the:
- Board of Directors
- Health care system
- Health care team
- PFAC
HRET Tools and Resources

- **HRET HIIN website**
  - Change packages
  - Toolkits
  - Webinars
  - Case studies
  - Infographics
  - Guideline
  - Storyboard
  - Reports
Thank You!

Questions? Please contact:

Lydie Marc, MPH, CHES

LMarc_CT@aha.org
Discussion

Use the chat box or phone to:
- Provide comments
- Ask a question, or
- share your story and lessons learned.
Moving Forward in Action

**HIINs**
- Share case studies that illustrate the impact of PFE on improving medical diagnoses
- Help hospitals educate and train frontline staff on how to partner with patients and families to improve medical diagnosis

**Hospitals**
- Include patients and families as members of the diagnostic team
- Partner with your PFAC to identify and address opportunities to better engage patients and families in the diagnostic process
Tools and Resources

• Strategic Vision Roadmap for PFE (PFEC)*


• Society to Improve Diagnosis in Medicine: https://www.improvediagnosis.org/

Stay Tuned for More from the PFEC

The monthly PFE Learning Events take place the **second Thursday of each month** from 1:00-2:00 p.m. ET.

Watch your inbox for information about the next PFE Learning Event, occurring on **March 14**!

Do you have a best practice or success story to share? Please let us know at PFE@air.org.
Thank You!

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