



{PLENARY SESSION}

Research Summit:

Improving Diagnosis in Health Care

Jeffrey Brady, MD, MPH
Director, Center for Quality Improvement and Patient Safety
AHRQ Research Summit on Diagnostic Safety
September 28, 2016

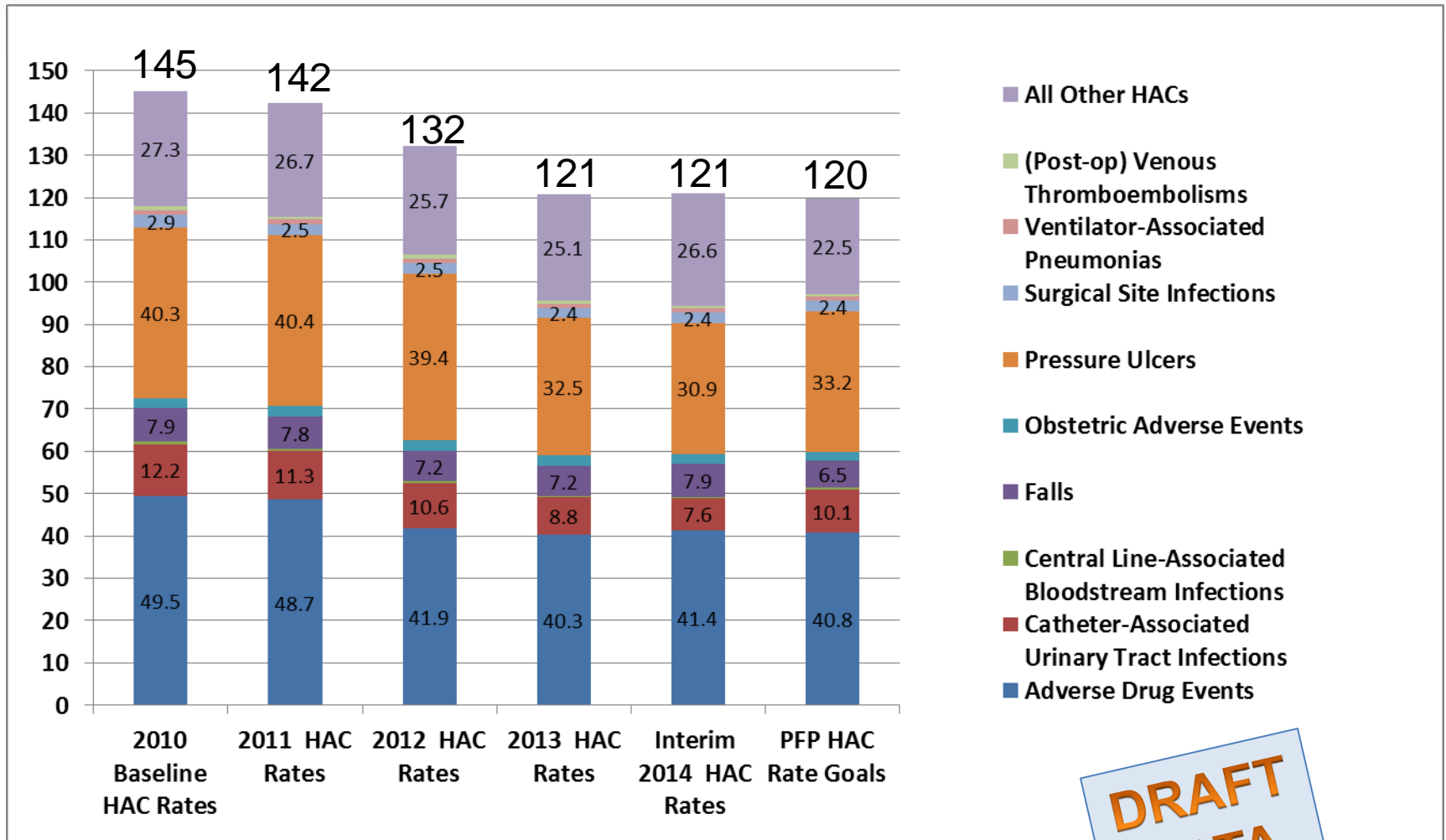


Presentation Agenda

- National Progress in Hospital Safety
 - ▶ Measurable improvement, but some harm persists
- AHRQ Research and Implementation Programs
 - ▶ Applicability to Improving Diagnosis
- Improving Diagnosis in Medicine Research Summit
 - ▶ Plan for the Day



National Hospital-Acquired Condition (HAC) rate: 2010 to 2014 (interim data)



DRAFT DATA



Unprecedented Improvements in Hospital Safety and Measurable Impact



**17% reduction
in HACs**



**87,000 lives
saved**



**2.1 million
patient harms
avoided**



**\$19.8 billion in
savings**

Saving Lives and Saving Money: Hospital-Acquired Conditions Update Interim Data From National Efforts To Make Care Safer, 2010-2014 : <http://www.ahrq.gov/news/newsroom/press-releases/2015/saving-lives.html>



Patient Safety in the United States: National Progress, but Harm Persists

2010:	145 Harms/1,000 Discharges
2011:	142 Harms/1,000 Discharges
2012:	132 Harms/1,000 Discharges
2013:	121 Harms/1,000 Discharges
2014:	121 Harms/1,000 Discharges

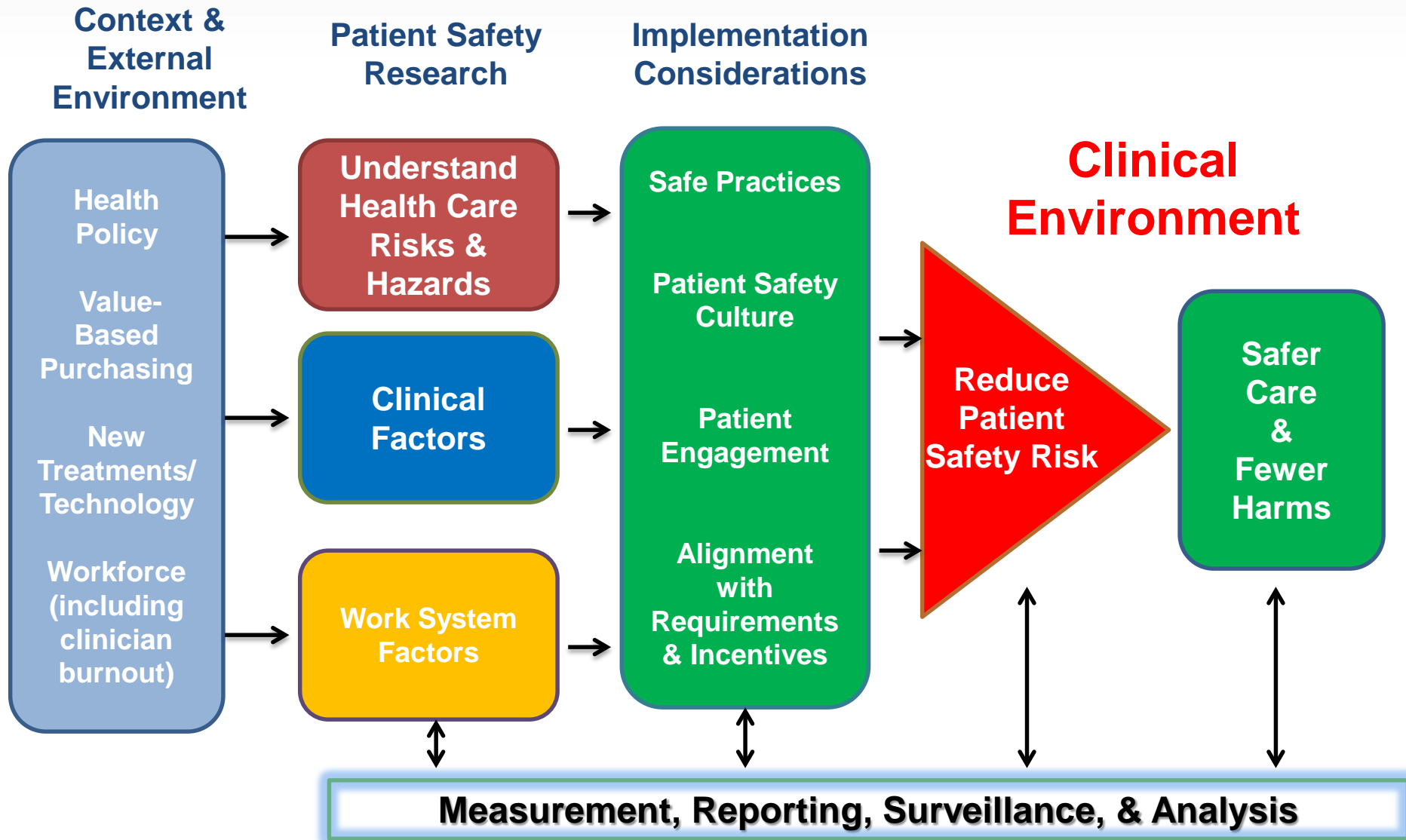


How AHRQ Makes a Difference

- AHRQ **invests in research and evidence** to understand how to make health care safer and improve quality
- AHRQ creates materials to **teach and train** health care systems and professionals to **catalyze** improvements in care
- AHRQ **generates measures and data** used to track and improve performance and evaluate progress of the U.S. health system



Patient Safety Program Framework





A Sample of AHRQ Supported Dx Studies in Primary Care

- Determine types of diseases missed and processes involved in confirmed Dx error cases using EHR triggers (unexpected return visits after initial primary care visit) *Singh et al., 2013*
- Conduct survey of physicians for recall of Dx error using a phase-based taxonomy (e.g., history taking, examination, tests, referrals, follow-up) to determine perceived causes, seriousness, and frequency *Schiff et al., 2009*
- Identify diagnostic pathways (involving Dx testing, processes, prescriptions, referral, and follow-up) using EHR data to study undifferentiated abdominal pain *Rao et al., in process*



Patient Safety Tools and Resources

<http://www.ahrq.gov/professionals/quality-patient-safety/patient-safety-resources/>



AHRQ Patient Safety Tools and Resources

The Agency for Healthcare Research and Quality (AHRQ) offers practical, research-based tools and resources to help a variety of health care organizations, providers, and others make care safer in all health care settings.

Contents

Building Capacity To Make Care Safer	1
Measuring Patient Safety	2
Addressing Priority Areas	3
Tools for Hospitals	3
Tools for Emergency Departments	4
Tools for Long-Term Care Facilities	4
Tools for Ambulatory Care Settings	5
Engaging Patients and Families In Their Care	5
General Patient Safety/Quality Resources	7

Building Capacity To Make Care Safer

These tools and resources help health care providers understand and benchmark their patient safety efforts, improve team-based care, and use the latest evidence to prevent healthcare-associated infections.

AHRQ Patient Safety Culture Surveys, a suite of staff-administered surveys that help providers in various settings of care examine patient safety culture from the staff perspective, assess the organizational safety culture, identify areas for improvement, and track changes over time. Database reports for the hospital, nursing home,

community pharmacy, and medical office surveys provide high-level overviews of trends in survey responses over time.

Surveys available for:

- Hospitals
- Nursing homes
- Medical offices
- Community pharmacies
- Ambulatory surgery centers

Web: ahrq.gov/qual/patientsafetyculture

Team Strategies and Tools To Enhance Performance and Patient Safety 2.0 (TeamSTEPPS®)

A core curriculum, is a customizable program plus specialized tools to reduce risks to patient safety by training clinicians in teamwork and communication skills. Materials include a leader's guide for trainers, a pocket guide of important concepts for trainees, and a multimedia guide featuring training videos to illustrate various concepts. Additional modules address the needs of rapid response teams and staff treating patients with limited English skills. Online modules also are available.

In addition to the core curriculum, the following versions are available:

- Long-term care
- Office-based care

Web: ahrq.gov/teamsteps



 Check out AHRQ's New Patient Safety YouTube Channel
youtube.com/ahrqpatientsafety



Agency for Healthcare Research and Quality
Advancing Excellence in Health Care • www.ahrq.gov



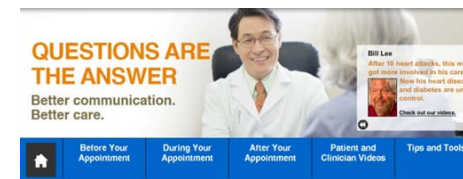


AHRQ Products Applicable to Improving Diagnostic Safety

- Improving Your Office Testing Process: Toolkit for Rapid-Cycle Patient Safety and Quality Improvement



- Questions Are the Answer



- Hospital Guide to Patient and Family Engagement

- TeamSTEPPS





Improving Your Office Testing Process: Toolkit for Rapid-Cycle Patient Safety and Quality Improvement

(relevant to Goals 4 & 5)

- Toolkit helps medical offices assess and improve the process they use to manage patient testing and follow-up
- Includes surveys, survey scoring sheets, and patient handouts
 - ▶ Surveys of office readiness, testing processes, and patient engagement (English and Spanish)
 - ▶ Tools for planning, chart audit, and electronic health record evaluation
 - ▶ A patient handout (English and Spanish)
- Users can choose among these surveys and tools to select the ones that apply to their office





Improving Diagnosis in Medicine Research Summit

“Plan for the Day”

- Morning plenary session to set the stage
- Breakout sessions to address important topics and potential solutions:
 - ▶ Use of Data and Measurement
 - ▶ Health IT's Role
 - ▶ Organizational Factors and their Impact

 - ▶ Cross-cutting
 - Patient and Family Engagement
 - Professional Education and Training
- Highlights in afternoon, full-group session in order to “reassemble” parts of the system and consider next steps