

# **Diagnostic Excellence Pilot Survey**

## **Domain 1: Leadership Structures & Systems**

**Hard Copy**

**Domain 1: Leadership Structures and Systems**

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## **Domain 1: Leadership Structures and Systems**

### Welcome to the Recognizing Excellence in Diagnosis Pilot

Thank you for participating in the Recognizing Excellence in Diagnosis Pilot. The Pilot includes two components:

1. **Pilot Survey** – The Pilot Survey is designed to assess your hospital’s familiarity with and progress towards implementing the recommended practices published in the [Recognizing Excellence in Diagnosis: Recommended Practices for Hospitals](#) report published by Leapfrog in July 2022. Each hospital participating in the pilot is assigned either the sixteen recommended practices from Domain 1: Leadership Structures & Systems or the thirteen practices from Domain 2: The Diagnostic Process.
2. **SIDM Playbook Testing** – The SIDM Playbook is designed to help hospitals implement one of the recommended practices in the report focused on patient engagement. Each hospital participating in the pilot that has a Patient Family Advisory Council (PFAC) is asked to review the Playbook, which has three parts, and to provide feedback on the usability, clarity, and effectiveness.

To get started on the Pilot Survey, please carefully review the instructions, definitions of terms, implementation scale, and questions in the [Hard Copy of the Survey](#). The questions in the Hard Copy of the Survey match the questions in the Qualtrics Survey exactly.

To get started on the SIDM Playbook Testing, please review the three resources and feedback form with instructions: [SIDM Playbook Testing](#).

#### **Important Notes:**

1. Your hospital has been assigned to **Domain 1: Leadership Structures & Systems**. Only those questions specific to Domain 1 are included in the Hard Copy and Qualtrics Survey.
2. Leapfrog will only accept responses to the Pilot Survey submitted via Qualtrics, a secure online data collection tool. Access Qualtrics using the customized Survey link emailed directly to your hospital’s contact.
3. Leapfrog will not score or publicly report responses to the Pilot Survey. The responses will be used in confidential benchmarking reports for pilot participants and aggregated for a national report published in March 2023.
4. The Pilot Survey (and customized Survey link) will close at midnight EST on **December 31, 2022**. If your hospital does not submit the Pilot Survey via Qualtrics by December 31, you will not receive a confidential benchmarking report or be included in the national report.

Visit our website for more information about the Recognizing Excellence in Diagnosis program:

<https://www.leapfroggroup.org/influencing/recognizing-excellence-diagnosis>.

Contact the [Help Desk](#) if you have any questions.

## Instructions for Participating in the Pilot Survey

**Note 1:** Please carefully review these instructions and the [Instructions for Qualtrics](#) before you begin.

**Note 2:** Each question in Qualtrics must be completed before you can submit the Pilot Survey. Once you submit the Pilot Survey, you will not be able to go back and make updates to your responses.

1. Prepare - Download and review Leapfrog's [Recognizing Excellence in Diagnosis: Recommended Practices for Hospitals](#).
2. Form a Pilot Survey Team – Identify and recruit individuals at your hospital that are knowledgeable about any effort or intervention to reduce or prevent [diagnostic errors](#) (e.g., risk managers, quality directors, clinicians from the ED, radiology, lab, ICUs, nurses, pharmacists, members of your hospital's PFAC, board members, and others).
3. Review Materials – Send your team a Hard Copy of the Pilot Survey so they can review the questions, definitions, and implementation scale and let them know how you will collect information from them to determine your hospital's progress on each recommended practice using the implementation scale (e.g., lunch meeting, Zoom poll, etc.).
4. Collect Responses – Once your team has reviewed the questions, definitions, and implementation scale, collect, and process their feedback. This information should be used to record responses to the questions in the Hard Copy of the Pilot Survey. If you receive conflicting information, resolve the conflicts before you start recording responses (i.e., one team member reports “not under consideration” and another reports “exploring and preparing”). We recommend that you complete the Hard Copy before entering the responses into Qualtrics.
5. Complete the Pilot Survey via Qualtrics – Now that the Hard Copy of the Pilot Survey is completed, you are ready to access Qualtrics using the customized Survey link sent to your hospital's contact. Can't find the link? Contact the [Help Desk](#). Be sure to review the [Instructions for Qualtrics](#) before you start.
6. Reminders –
  - a. You do not need to collect any data.
  - b. You do not need to collect any documentation.
  - c. You should answer the questions based on your individual hospital's implementation progress. Do not answer the questions based on efforts or interventions being planned or implemented at other hospitals, outpatient clinics, or physician practices in your health system.
  - d. If you have questions, contact the [Help Desk](#).

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### Instructions for Using Qualtrics

**Note 1:** If your hospital's name, address, and CCN is not displayed correctly on the Profile page in Qualtrics, **STOP** and contact the Help Desk immediately. We may need to send you a new customized link.

1. Each question in Qualtrics is required and should be completed in numerical order.
2. However, if you need to navigate back to a previous question to update a response, you can do so by using the left arrow button at the bottom of the screen and then use the right arrow button to advance forward.



3. As you enter responses into Qualtrics, they will be automatically saved. You can close your browser and re-use the customized link to access Qualtrics repeatedly until you submit your responses. Use the arrow keys at the bottom of the screen to advance pick up where you left off.
4. Once you have completed each numbered question, you will be prompted to confirm that you are ready to submit the Survey via Qualtrics. If you select "YES, I have reviewed my responses and am prepared to submit," you will be taken directly to a page where you can print your responses. **DO NOT CLOSE THE BROWSER** until you print your responses on the next page. You will not be able to access Qualtrics after you submit the Survey.

 Please use the Back/Left Arrow Key at the bottom of your screen to review your previous responses.

Have you reviewed your survey responses, and are you prepared to finalize your submission?

WARNING: Once you select "YES, I have reviewed my responses and am ready to submit" and proceed to the next page, you will not be able to return to Qualtrics. Remember to print your responses using the link on the following page.

YES, I have reviewed my responses and am prepared to submit.

NO, I need to go back and review my responses



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5. After submitting the Survey via Qualtrics, you will be able to print your responses. Use the “Download PDF” link to print the questions and responses. A PDF copy of your responses will also be e-mailed to the primary survey contact for your records. You will not be able to access Qualtrics after you submit the Survey.

Below is a summary of your responses

[Download PDF](#)

## **Domain 1: Leadership Structures and Systems**

### Definitions of Terms Used in the Pilot Survey

Please review the definitions of terms used in the Pilot Survey with your team before you begin. These terms are hyperlinked throughout the questions.

**Care team:** A group of healthcare professionals who collectively take responsibility for a set of patients. Care teams blend multidisciplinary skills, focusing insights of several people rather than a single clinician on each patient's problems (adapted from [AHRQ](#)).

**Clinicians:** Healthcare professionals qualified for clinical practice (providing direct care to patients). Clinicians include physicians, nurses, pharmacists, or other allied health professionals (adapted from [CMS](#)).

**Diagnostic error:** An event where one or both of the following occurred, with harm or high potential of harm to the patient:

- Delayed, wrong, or missed diagnosis: At least one missed opportunity to pursue or identify an accurate and timely diagnosis based on the information that existed at that time
- Diagnosis not communicated to the patient: Accurate diagnosis was available but was not effectively communicated to the patient or family

This definition is adapted from the definition of a “diagnostic safety event” from the [2021 AHRQ Common Formats for Event Reporting – Diagnostic Error](#).

**Diagnostic excellence:** Making and communicating a correct and timely diagnosis using appropriate resources while maximizing patient experience and managing uncertainty.

**Diagnostic process:** A process that starts with the patient's first engagement with the health care system and ends with clinicians either communicating a timely and correct diagnosis or learning from a diagnostic error or near miss that contributed to the patient's clinical outcomes. In that timeframe, clinicians and others involved in caring for the patient gather information, integrate and interpret that information, formulate a diagnosis, communicate the diagnosis to the patient, and develop a plan of care based on the diagnosis (adapted from the National Academy of Medicine's [Improving Diagnosis in Health Care](#), 2015).

**Escalation of care:** The transfer of a patient to a higher level of care. For example, transferring a patient from a medical unit to a telemetry unit or from a telemetry unit to a critical care unit.

**Rapid response:** An urgent, team-based re-evaluation of a patient whose clinical condition is deteriorating. A “rapid response” can be initiated by the clinical staff (typically nurses or respiratory therapists) and in some hospitals, by the patient or family.

**Family caregiver:** Any relative, partner, friend or neighbor who has a significant personal relationship with, and provides a broad range of assistance for, a person receiving medical care or long-term care services such as an older person, a child, or an adult with a chronic or disabling condition. These individuals may be primary or secondary caregivers and live with, or separately from, the person receiving care (adapted from the [Family Caregiver Alliance](#)).

**Patient and Family Caregiver Advisory Council:** A patient and family advisory council (PFAC) is an organization of current and former patients, family members and caregivers that works together to advance best practices at a hospital or healthcare organization. Volunteer patients and families

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collaborate with employees (clinical, administrative and support) to provide guidance on how to improve the patient and family experience (adapted from [Johns Hopkins Medicine](#)).

**Recommended practices:** Practices for which there is some clear rationale (recommended by subject matter experts and/or peer-reviewed literature) that links the practice to improvements in the diagnostic process and/or diagnostic outcomes in hospitals.

**Senior administrative leaders:** Individuals responsible for hospital-wide departments or services (e.g., Chief Executive Officer, Chief Administrative Officer, Chief Nursing Officer, Chief Medical Officer).

**Others involved in the diagnostic process:** Healthcare professionals that include, but are not limited to, radiologists, pathologists, laboratory personnel, and others.



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### The Implementation Scale

Please review the implementation scale used in the Pilot Survey with your team before you begin. This implementation scale is repeated for each recommended practice.

1. Not under consideration – No one at our hospital has initiated any discussions about implementing this practice.
2. Exploring and Preparing – One or more individuals at our hospital have discussed the practice and started engaging additional staff and senior administrative leadership around implementation of some or all elements of this practice.
3. Planning and Resourcing – Our hospital has an implementation strategy, and the necessary resources (staff and budget) are in place to implement some or all elements of this practice in the next 12 months.
4. Implementing and Operationalizing – Our hospital has recently implemented some or all elements of this practice in one or more departments or units.
4. Fully Implemented and Evaluating Impact – Our hospital has fully implemented ALL elements of the practice in ALL applicable departments or units (e.g., both in the emergency department AND all applicable inpatient or outpatient units) or hospital-wide and is monitoring our progress and outcomes.

## **Domain 1: Leadership Structures and Systems**

### Technical Assistance

The [Help Desk](#) is available to provide your hospital with technical assistance and answers to questions Monday-Friday from 9:00 am to 5:00 pm ET. Help Desk support staff typically respond to inquiries within 1-2 business days (see [Help Desk Holiday Schedule for planned closures](#)).

Help Desk tickets can be submitted electronically at <https://leapfroghelpdesk.zendesk.com>. You will receive a confirmation email and response from [support@leapfroghelpdesk.zendesk.com](mailto:support@leapfroghelpdesk.zendesk.com). **To ensure that you receive our emails, please work with your IT Team to add the following to your safe sender list:**

- @leapfrog-group.org
- @leapfroghelpdesk.zendesk.com
- @em4073.leapfrog-group.org
- IP address: 159.183.167.150

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### Profile

If your hospital's name, address, and CMS Certification Number are not displayed correctly in Qualtrics, please contact the [Help Desk](#).

<b>Organization Name</b>
<i>Pre-populated in the Qualtrics survey by Leapfrog</i>
<b>Address (Street, City, State, Zip Code)</b>
<i>Pre-populated in the Qualtrics survey by Leapfrog</i>
<b>CMS Certification Number (CCN)</b>
<i>Pre-populated in the Qualtrics survey by Leapfrog</i>
<b>Leapfrog ID</b>
<i>Pre-populated in the Qualtrics survey by Leapfrog</i>

<b>Contact Name</b>
<i>Required</i>
<b>Title</b>
<i>Required</i>
<b>Email Address</b>
<i>Required</i>
<b>Phone Number</b>
<i>Required</i>

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Pilot Survey Questions

Respond to each of the following questions based on your hospital’s implementation progress at the time you are submitting the Pilot Survey.

Recommended Practice 1.1A

**1. As it specifically relates to reducing errors in diagnosis (including delayed, wrong, or missed diagnoses, and diagnoses not communicated to the patient), what is your hospital’s progress in implementing practice 1.1A?**

Practice 1.1A: [Senior administrative leaders](#) both

- Establish separate goals for all the following:
  - Engaging patients,
  - Improving communication between patients and their [care team](#),
  - Promoting better communication and teamwork between members of the [care team](#) to reduce errors in diagnosis,

AND
- Are held accountable for these goals in all the following ways:
  - Sharing these goals with the Board and throughout the organization,
  - Communicating progress towards meeting these goals at least annually to the Board, and
  - Including progress towards meeting these goals in the [senior administrative leaders’](#) annual performance reviews, incentives, or compensation.

*If “not under consideration,” continue to question 2. Otherwise, move on to question 1a.*

<b>Not under consideration</b>	<b>Exploring and Preparing</b>	<b>Planning and Resourcing</b>	<b>Implementing and Operationalizing</b>	<b>Fully Implemented and Evaluating Impact</b>
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**1a: Were any of the following resources or strategies used on your path to implement Practice 1.1A? If you used a resource or strategy not listed here, select “Other” and provide a brief description.**

**Select all that apply.**

<b>o</b>	<a href="#">Senior administrative leaders</a> use <a href="#">AHRQ’s Guide to Patient and Family Engagement or AHRQ’s Toolkit for Engaging Patients to Improve Diagnostic Safety</a> to set goals that align with organizational priorities and needs related to patient engagement.
<b>o</b>	<a href="#">Senior administrative leaders</a> set a goal to partner with the hospital’s Patient and Family Advisory Council ( <a href="#">PFAC</a> ) to identify opportunities to reduce errors in diagnosis (including, delayed, wrong, or missed diagnoses, and diagnoses not communicated to the patient) and implement <a href="#">PFAC</a> recommendations (e.g., recommendations on engaging patients in their

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	own diagnosis, following up on pending test results at discharge, increasing interaction with the patient portal, giving patients opportunities to report diagnostic concerns).
o	<a href="#">Senior administrative leaders</a> set a goal to involve a <a href="#">PFAC</a> member in another hospital-wide or departmental committee working to reduce errors in diagnosis (including delayed, wrong, or missed diagnoses, and diagnoses not communicated to the patient).
o	<a href="#">Senior administrative leaders</a> use the American Institutes for Research <a href="#">Roadmap for Patient and Family Engagement in Healthcare</a> or the Patient Safety Foundation’s <a href="#">Actionable Patient Safety Solution: Person and Family Engagement</a> to design and implement programs to improve patient engagement at the hospital.
o	<a href="#">Senior administrative leaders</a> use <a href="#">AHRQ’s TeamSTEPPS® for Diagnosis Improvement</a> to set goals for staff training that align with organizational priorities and needs related to communication and teamwork between members of the <a href="#">care team</a> .
o	<a href="#">Senior administrative leaders</a> set a goal to measure and improve nurse and clinical pharmacist perceptions of being a valued member of the diagnostic team (e.g., the rate at which nurses and clinical pharmacists actively participate on rounds).
o	<a href="#">Senior administrative leaders</a> monitor and display (e.g., internal newsletter or intranet) run charts that track percentage of staff trained using <a href="#">AHRQ’s TeamSTEPPS® for Diagnosis Improvement</a> .
OTHER	_____

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Recommended Practice 1.1B

**2: As it specifically relates to reducing errors in diagnosis (including delayed, wrong, or missed diagnoses, and diagnoses not communicated to the patient), what is your hospital’s progress in implementing practice 1.1B?**

Practice 1.1B: [Senior administrative leaders](#) convene a multidisciplinary team sponsored by the Chief Medical Officer, or other senior administrative leader, that meets all the following criteria:

- The team establishes a leader who regularly reports to the executive sponsor,
- At a minimum, the team includes representatives from nursing, pharmacy, laboratory medicine, radiology, and the ED,
- The team leader communicates quarterly with the Board and other [senior administrative leaders](#) on issues related to reducing errors in diagnosis (including delayed, wrong, or missed diagnoses, and diagnoses not communicated to the patient),
- The team leader convenes staff from key clinical departments (including at least, if applicable, ED, hospital medicine, pediatrics, surgery, radiology, and obstetrics, intake or transfer coordinators, case management, pathology, radiology, and laboratory) quarterly to discuss strategies to reduce errors in diagnosis issues and any lessons learned from specific patient cases,
- Designated members of the team collaborate with [others involved in the diagnostic process](#) to ensure [diagnostic errors](#) identified by the hospital undergo a root cause analysis and ensure the findings are shared with the staff involved in the case. If the patient was harmed, actions to prevent future similar errors are shared with the patient (and/or [family caregiver](#)), and
- Designated members of the team collaborate with other staff to evaluate the implementation of programs (e.g., [AHRQ’s TeamSTEPPS® for Diagnosis Improvement](#)) aimed at reducing errors in diagnosis (including delayed, wrong, or missed diagnoses, and diagnoses not communicated to the patient) and to make recommendations for further training.

*If “not under consideration,” continue to question 3. Otherwise, move on to question 2a.*

<i>Not under consideration</i>	<i>Exploring and Preparing</i>	<i>Planning and Resourcing</i>	<i>Implementing and Operationalizing</i>	<i>Fully Implemented and Evaluating Impact</i>
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**2a: Was the following resource or strategy used on your path to implement Practice 1.1B? If you used a resource or strategy not listed here, select “Other” and provide a brief description.**

**Select all that apply.**

<input type="radio"/>	Our hospital hired a physician dedicated full time to convene a multidisciplinary team and lead their work.
OTHER	_____

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Recommended Practice 1.1C

<p><b>3: As it specifically relates to reducing errors in diagnosis (including delayed, wrong, or missed diagnoses, and diagnoses not communicated to the patient), what is your hospital’s progress in implementing practice 1.1C?</b></p> <p>Practice 1.1C: <a href="#">Senior administrative leaders</a> communicate information regarding cases of errors in diagnosis, efforts to reduce errors in diagnosis, and the outcomes of those efforts both internally (e.g., hospital staff and hospital committees) and externally (e.g., patients and <a href="#">family caregivers</a>, the community, other institutions), and to the board of directors. This includes specific activities related to error reduction, the results of interventions that have been implemented, and lessons learned from analysis of <a href="#">diagnostic errors</a>.</p> <p><i>If “not under consideration,” continue to question 4. Otherwise, move on to question 3a.</i></p>				
<i>Not under consideration</i>	<i>Exploring and Preparing</i>	<i>Planning and Resourcing</i>	<i>Implementing and Operationalizing</i>	<i>Fully Implemented and Evaluating Impact</i>

**3a: Were any of the following resources or strategies used on your path to implement Practice 1.1C? If you used a resource or strategy not listed here, select “Other” and provide a brief description.**

**Select all that apply.**

<input type="radio"/>	<a href="#">Senior administrative leaders</a> share information and updates on our hospital’s efforts to reduce errors in diagnosis (including delayed, wrong, or missed diagnoses, and diagnoses not communicated to the patient), including lessons learned, goals, and programs through a monthly internal newsletter or the organization’s intranet.
<input type="radio"/>	Our hospital publishes information on lessons we’ve learned to reduce errors in diagnosis (such as learnings related to reducing delayed, wrong, or missed diagnoses, and reducing diagnoses not communicated to the patient), goals and programs on our website or through a community newsletter or annual report.
<input type="radio"/>	Our hospital highlights programs initiated to improve diagnosis (such as reductions in delayed, wrong, or missed diagnoses, and diagnoses not communicated to the patient) in press releases or at community events.
<input type="radio"/>	Our hospital shares information on efforts to improve diagnosis (such as learnings related to reducing delayed, wrong, or missed diagnoses, and reducing diagnoses not communicated to the patient) with other hospitals and organizations through quality reports or research results published in scientific journals.
OTHER	_____

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Recommended Practice 1.2A

**4: As it specifically relates to reducing errors in diagnosis (including delayed, wrong, or missed diagnoses, and diagnoses not communicated to the patient), what is your hospital’s progress in implementing practice 1.2A?**

Practice 1.2A: The hospital CEO demonstrates a commitment to [diagnostic excellence](#) through a written or verbal commitment delivered to all staff, stating that the advancement of [diagnostic excellence](#) is a priority for the organization.

*If “not under consideration,” continue to question 5. Otherwise, move on to question 4a.*

<i>Not under consideration</i>	<i>Exploring and Preparing</i>	<i>Planning and Resourcing</i>	<i>Implementing and Operationalizing</i>	<i>Fully Implemented and Evaluating Impact</i>
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**4a: Were any of the following resources or strategies used on your path to implement Practice 1.2A? If you used a resource or strategy not listed here, select “Other” and provide a brief description.**

**Select all that apply.**

<input type="checkbox"/>	Our hospital’s CEO, in partnership with the hospital’s <a href="#">PFAC</a> , sponsors an all-staff event to announce new goals or a new initiative to advance <a href="#">diagnostic excellence</a> .
<input type="checkbox"/>	Our hospital’s CEO participates in a series of “town hall” style talks on <a href="#">diagnostic excellence</a> .
<input type="checkbox"/>	Our hospital’s CEO identifies or designates “champions” of <a href="#">diagnostic excellence</a> in high-risk departments (e.g., the ED, radiology, laboratory medicine, critical care) and introduces them to the organization as leaders of diagnostic-improvement projects.
<input type="checkbox"/>	Our hospital’s CEO writes a newsletter that is distributed to all staff or a blog on the intranet to share their commitment to <a href="#">diagnostic excellence</a> .
OTHER	_____



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Recommended Practice 1.2B

**5: As it specifically relates to reducing errors in diagnosis (including delayed, wrong, or missed diagnoses, and diagnoses not communicated to the patient), what is your hospital’s progress in implementing practice 1.2B?**

Practice 1.2B: [Senior administrative leaders](#) promote effective teamwork in diagnosis by instituting policies or protocols that encourage all the following:

- Diagnostic input and second opinions from [clinician](#) peers,
- Diagnostic input from nurses, pharmacists, and other clinical staff who touch the patient, and
- Communication among [clinicians](#) and [others involved in the diagnostic process](#) and staff in radiology and the clinical lab regarding test selection and test result interpretation.

*If “not under consideration,” continue to question 6. Otherwise, move on to question 5a.*

<i>Not under consideration</i>	<i>Exploring and Preparing</i>	<i>Planning and Resourcing</i>	<i>Implementing and Operationalizing</i>	<i>Fully Implemented and Evaluating Impact</i>

**5a: Were any of the following resources or strategies used on your path to implement Practice 1.2B? If you used a resource or strategy not listed here, select “Other” and provide a brief description.**

**Select all that apply.**

<input type="radio"/>	Our hospital designates individuals to be trained as facilitators using AHRQ’s <a href="#">Facilitator’s Implementation Roadmap</a> . Trained facilitators then teach the <a href="#">TeamSTEPPS for Diagnosis Improvement</a> course to small teams of <a href="#">clinicians</a> and <a href="#">others involved in the diagnostic process</a> .
<input type="radio"/>	Our hospital practices interdisciplinary patient rounding in inpatient and critical care units. As part of the practice of interdisciplinary rounding, nurses, pharmacists, and allied health professionals engage in the discussions and contribute to decisions about the patient’s diagnosis.
<input type="radio"/>	Physicians in the ED consult with colleagues, including nurses, pharmacists, radiologists, and laboratory staff before discharge or admission to an inpatient unit to get input on key diagnostic information.
<input type="radio"/>	Our hospital has a standard protocol in place where patients with an uncertain diagnosis at a specific point-in-time (48 to 72 hours after admission) automatically get a second review by a different clinical team.
<input type="radio"/>	Our hospital has a policy to include radiologists on tumor boards and in multidisciplinary conferences.
<input type="radio"/>	Pathologists provide feedback to other <a href="#">clinicians</a> about test selection choices and successes and failures in interpretation of results
OTHER	_____

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Recommended Practice 1.2C

<p><b>6: As it specifically relates to reducing errors in diagnosis (including delayed, wrong, or missed diagnoses, and diagnoses not communicated to the patient), what is your hospital’s progress in implementing practice 1.2C?</b></p> <p>Practice 1.2C: The hospital targets training and education specific to the <a href="#">diagnostic process</a> to nurses, pharmacists, and other allied health professionals.</p> <p><i>If “not under consideration,” continue to question 7. Otherwise, move on to question 6a.</i></p>				
<i>Not under consideration</i>	<i>Exploring and Preparing</i>	<i>Planning and Resourcing</i>	<i>Implementing and Operationalizing</i>	<i>Fully Implemented and Evaluating Impact</i>

**6a: Were any of the following resources or strategies used on your path to implement Practice 1.2C? If you used a resource or strategy not listed here, select “Other” and provide a brief description.**

**Select all that apply.**

<input type="radio"/>	Our hospital ensures that nurses, pharmacists, and other allied health professionals are included in trainings on <a href="#">AHRQ’s TeamSTEPPS® for Diagnosis Improvement</a> .
<input type="radio"/>	Our hospital has modified existing courses (e.g., courses on interdisciplinary communication identification of sepsis, or when to call a <a href="#">Rapid Response</a> Team) to explicitly link the course content to the <a href="#">diagnostic process</a> and through the delivery of the course ensures that nurses, pharmacists, allied health professionals, and staff from radiology and laboratory medicine understand their role in the <a href="#">diagnostic process</a> .
<input type="radio"/>	Our hospital ensures that targeted training to nurses, pharmacists, and allied health professionals is applied during interprofessional patient rounds to ensure that all individuals participating in interprofessional rounding actively participate in the discussions and contribute to decisions about the patient’s diagnosis.
OTHER	_____

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Recommended Practice 1.2D

**7: As it specifically relates to reducing errors in diagnosis (including delayed, wrong, or missed diagnoses, and diagnoses not communicated to the patient), what is your hospital’s progress in implementing practice 1.2D?**

Practice 1.2D: The hospital has a formal process in place for staff to report [diagnostic errors](#) and concerns (e.g., breakdowns in communication, breakdowns in the [diagnostic process](#)). The process encourages psychological safety for those sharing their cases and staff adoption (the process is safe and easy to use) and should include all the following:

- Staff training on how and when to report [diagnostic errors](#) and concerns,
- A formal protocol for investigating, responding to, and learning from staff-reported [diagnostic errors](#), concerns, or questions,
- A formal protocol for non-punitively notifying [clinicians](#) involved in the patient’s care and supportively engaging with them in any investigations,
- An emphasis on transparency, and
- A formal protocol for soliciting feedback from hospital staff on the psychological safety and usability of the process.

*If “not under consideration,” continue to question 8. Otherwise, move on to question 7a.*

<i>Not under consideration</i>	<i>Exploring and Preparing</i>	<i>Planning and Resourcing</i>	<i>Implementing and Operationalizing</i>	<i>Fully Implemented and Evaluating Impact</i>

**7a: Were any of the following resources or strategies used on your path to implement Practice 1.2D? If you used a resource or strategy not listed here, select “Other” and provide a brief description.**

**Select all that apply.**

<input type="radio"/>	Our hospital has an easy-to-use system to facilitate reporting of <a href="#">diagnostic errors</a> and diagnosis-related concerns, either through a mobile application or hotline.
<input type="radio"/>	Our hospital uses its incident/event reporting system to include <a href="#">diagnostic errors</a> and concerns, regularly reminds <a href="#">clinicians</a> and other staff to use the system and reports out on usage statistics on a regular basis.
<input type="radio"/>	<a href="#">Senior administrative leaders</a> regularly review the number and type of <a href="#">diagnostic errors</a> and concerns being reported and provides retraining opportunities, reminders, and incentives (e.g., a component of performance evaluations) to encourage reporting of <a href="#">diagnostic errors</a> and concerns by <a href="#">clinicians</a> and <a href="#">others involved in the diagnostic process</a> , if gaps in usage are identified.
<input type="radio"/>	Our hospital considers the terms and language used in the reporting process. For example, on an electronic reporting form, the term “ <a href="#">diagnostic error</a> ” is rephrased as an “opportunity to make a more accurate or timely diagnosis” to encourage a broader range of reporting.
<input type="radio"/>	Our hospital pairs an easy-to-use electronic reporting system with a <a href="#">clinician</a> champion who reinforces the importance of event reporting.

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OTHER	
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**Domain 1: Leadership Structures and Systems**

Recommended Practice 1.2E

**8: As it specifically relates to reducing errors in diagnosis (including delayed, wrong, or missed diagnoses, and diagnoses not communicated to the patient), what is your hospital’s progress in implementing practice 1.2E?**

Practice 1.2E: The hospital has a formal process in place for notifying patients and/or their [family caregivers](#) when [diagnostic errors](#) resulting in harm have occurred.

*If “not under consideration,” continue to question 9. Otherwise, move on to question 8a.*

<i>Not under consideration</i>	<i>Exploring and Preparing</i>	<i>Planning and Resourcing</i>	<i>Implementing and Operationalizing</i>	<i>Fully Implemented and Evaluating Impact</i>

**8a: Were any of the following resources or strategies used on your path to implement Practice 1.2E? If you used a resource or strategy not listed here, select “Other” and provide a brief description.**

**Select all that apply.**

<input type="radio"/>	Our hospital includes <a href="#">diagnostic errors</a> along with other adverse events in its existing communication and disclosure policy, with a particular focus on cases of delayed, wrong, and missed diagnoses resulting in harm.
<input type="radio"/>	Our hospital has a standard process to identify potential <a href="#">diagnostic errors</a> and refers these cases for risk management review. Risk management applies a standard protocol to identify cases where the patient was harmed from a <a href="#">diagnostic error</a> , and then initiates a root cause analysis. Staff trained in the <a href="#">AHRQ CANDOR</a> program communicate with the patient and <a href="#">family caregiver</a> throughout the process of disclosure, response, and resolution.
<input type="radio"/>	Our hospital is part of the <a href="#">Pathway to Accountability, Compassion and Transparency (PACT) Collaborative</a> , or is implementing a Communication and Resolution Program consistent with the guidelines promulgated by <a href="#">Collaborative for Accountability and Improvement</a> .
OTHER	_____

**Domain 1: Leadership Structures and Systems**

Recommended Practice 1.3A

<p><b>9: As it specifically relates to reducing errors in diagnosis (including delayed, wrong, or missed diagnoses, and diagnoses not communicated to the patient), what is your hospital’s progress in implementing practice 1.3A?</b></p> <p>Practice 1.3A: The hospital provides patients and their <a href="#">family caregivers</a> with tools to help them communicate complete and accurate personal health information to the <a href="#">care team</a>.</p> <p><i>If “not under consideration,” continue to question 10. Otherwise, move on to question 9a.</i></p>				
<i>Not under consideration</i>	<i>Exploring and Preparing</i>	<i>Planning and Resourcing</i>	<i>Implementing and Operationalizing</i>	<i>Fully Implemented and Evaluating Impact</i>

**9a: Were any of the following resources or strategies used on your path to implement Practice 1.3A? If you used a resource or strategy not listed here, select “Other” and provide a brief description.**

**Select all that apply.**

<input type="radio"/>	Our hospital uses the AHRQ Toolkit for Engaging Patients to Improve Diagnostic Safety, which includes deploying <a href="#">Be The Expert On You</a> , a patient-facing strategy that prepares patients and their families to tell their personal health stories in a clear, concise way.
<input type="radio"/>	Our hospital includes links to evidence-based tools on its public website; for example, the Society to Improve Diagnosis in Medicine <a href="#">Patient’s Toolkit for Diagnosis</a> , a patient-designed toolkit available in English or Spanish, that helps patients clearly communicate their symptoms and health information.
OTHER	_____

**Domain 1: Leadership Structures and Systems**

Recommended Practice 1.3B

**10: As it specifically relates to reducing errors in diagnosis (including delayed, wrong, or missed diagnoses, and diagnoses not communicated to the patient), what is your hospital’s progress in implementing practice 1.3B?**

Practice 1.3B: The hospital does both of the following:

- Provides patients and [family caregivers](#) with multiple channels (e.g., grievance process, ombudsman, patient-generated incident reporting, patient portal, patient survey) to report [diagnostic errors](#) and concerns, and
- Has a formal process in place to investigate and respond to the patient-reported [diagnostic errors](#) and concerns.

*If “not under consideration,” continue to question 11. Otherwise, move on to question 10a.*

<i>Not under consideration</i>	<i>Exploring and Preparing</i>	<i>Planning and Resourcing</i>	<i>Implementing and Operationalizing</i>	<i>Fully Implemented and Evaluating Impact</i>
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**10a: Were any of the following resources or strategies used on your path to implement Practice 1.3B? If you used a resource or strategy not listed here, select “Other” and provide a brief description.**

**Select all that apply.**

<input type="radio"/>	Our hospital surveys patients to ask if they have identified errors in their electronic health record visit notes.
<input type="radio"/>	Our hospital maintains a patient experience department that ensures patients are encouraged and educated on how to report <a href="#">diagnostic errors</a> and concerns via telephone, e-mail, or in-person visits, ensures patients who file a concern are contacted to follow-up, and ensures the concerns are logged in an incident reporting system.
<input type="radio"/>	Our hospital analyzes patient concerns submitted in free text fields from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey.
OTHER	_____

**Domain 1: Leadership Structures and Systems**

Recommended Practice 1.3C

**11: As it specifically relates to reducing errors in diagnosis (including delayed, wrong, or missed diagnoses, and diagnoses not communicated to the patient), what is your hospital’s progress in implementing practice 1.3C?**

Practice 1.3C: The hospital has a standard, hospital-wide process that allows patients and [family caregivers](#) to escalate care that includes all the following:

- A written policy specifying that a patient or [family caregiver](#) can initiate the [escalation of care](#),
- A formal process for notifying patients and [family caregivers](#), verbally or in writing, about the policy and how to activate the process for an escalation in care, and
- Training for [clinicians](#) and [others involved in the diagnostic process](#), so they know how to respond to a patient or [family caregiver](#) once the process for the [escalation of care](#) has been activated.

*If “not under consideration,” continue to question 12. Otherwise, move on to question 11a.*

<i>Not under consideration</i>	<i>Exploring and Preparing</i>	<i>Planning and Resourcing</i>	<i>Implementing and Operationalizing</i>	<i>Fully Implemented and Evaluating Impact</i>
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**11a: Were any of the following resources or strategies used on your path to implement Practice 1.3C? If you used a resource or strategy not listed here, select “Other” and provide a brief description.**

**Select all that apply.**

<input type="radio"/>	Our hospital has a policy on the <a href="#">escalation of care</a> and the use of <a href="#">rapid response</a> teams that allows patients and <a href="#">family caregivers</a> to initiate the process. Information about activating the process is shared with patients when they are admitted to the hospital, and staff are trained on how to respond once the process has been initiated.
<input type="radio"/>	Our hospital logs activation of <a href="#">rapid response</a> teams and regularly reviews the log to identify patterns of activation and patient outcomes that could identify opportunities for local system improvement.
OTHER	_____



**Domain 1: Leadership Structures and Systems**

Recommended Practice 1.3D

**12: As it specifically relates to reducing errors in diagnosis (including delayed, wrong, or missed diagnoses, and diagnoses not communicated to the patient), what is your hospital’s progress in implementing practice 1.3D?**

Practice 1.3D: The hospital ensures that patients use the patient portal to review their test results and other diagnostic related information by doing all the following:

- Providing patients with written instructions in their preferred language for medical decision-making on how to access the portal during and after their hospital visit,
- Providing patients with access to the patient portal on tablets or other hospital-owned devices during their hospital visit (if applicable),
- Giving patients access to all the health information in their electronic medical records (with rare exceptions, for example to protect the privacy of a minor) without a fee and without delay,
- Regularly tracking patient use of the portal,
- Periodically soliciting feedback from patients on the usability of the portal, and
- Identifying barriers to use of patient portals and working to address them (e.g., language barriers, access to devices or internet).

*If “not under consideration,” continue to question 13. Otherwise, move on to question 12a.*

<i>Not under consideration</i>	<i>Exploring and Preparing</i>	<i>Planning and Resourcing</i>	<i>Implementing and Operationalizing</i>	<i>Fully Implemented and Evaluating Impact</i>
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**12a: Were any of the following resources or strategies used on your path to implement Practice 1.3D? If you used a resource or strategy not listed here, select “Other” and provide a brief description.**

**Select all that apply.**

<input type="radio"/>	Our hospital actively encourages patients to use the patient portal and develops a strategy for <a href="#">clinicians</a> to recommend using the patient portal during and after the hospital visit to access progress notes, discharge summaries, and test result notifications.
<input type="radio"/>	Our hospital trains both administrative (e.g., registration staff) and clinical staff on use of the portal so they can assist patients who seek help.
<input type="radio"/>	Our hospital monitors use of the patient portal (e.g., how often patients read information about their test results) and seeks input from patients to improve use.
<input type="radio"/>	Our hospital partners with its <a href="#">PFAC</a> to discuss strategies to improve patient use of the portal. This includes the hospital Chief Information Officer, or an equivalent, attending <a href="#">PFAC</a> meetings to discuss this topic and working with the <a href="#">PFAC</a> to identify avenues to communicate with patients in the broader community.
<input type="radio"/>	Our hospital partners with its patient portal vendor to build mechanisms for patients to report symptoms, outcomes, and electronically request modifications to the clinical information in the medical record, if these features are not already available.

**Domain 1: Leadership Structures and Systems**

o	Our hospital responds to inequities in patient portal use by implementing a policy expanding access to underserved communities, a mobile version of the patient portal, and/or a Spanish language version of the application.
OTHER	_____

**Domain 1: Leadership Structures and Systems**

Recommended Practice 1.4A

<p><b>13: As it specifically relates to reducing errors in diagnosis (including delayed, wrong, or missed diagnoses, and diagnoses not communicated to the patient), what is your hospital’s progress in implementing practice 1.4A?</b></p> <p>Practice 1.4A: The hospital conducts an annual risk evaluation using a standardized risk assessment tool (e.g., <a href="#">the Safer Dx Checklist</a>) to identify gaps in staffing and clinical expertise, tools and technology, and communication and teamwork that contribute to errors in diagnosis.</p> <p><i>If “not under consideration,” continue to question 14. Otherwise, move on to question 13a.</i></p>				
<i>Not under consideration</i>	<i>Exploring and Preparing</i>	<i>Planning and Resourcing</i>	<i>Implementing and Operationalizing</i>	<i>Fully Implemented and Evaluating Impact</i>

**13a: Were any of the following resources or strategies used on your path to implement Practice 1.4A? If you used a resource or strategy not listed here, select “Other” and provide a brief description.**

**Select all that apply.**

<input type="radio"/>	Our hospital has a small team of <a href="#">clinicians</a> and <a href="#">others involved in the diagnostic process</a> from the major clinical services (e.g., emergency department, inpatient, radiology, laboratory medicine) complete the <a href="#">Safer Dx Checklist</a> . <small>Error! Bookmark not defined.</small> Results from the checklist are used to develop goals and inform process improvements.
<input type="radio"/>	Our hospital conducts a hospital-wide assessment of <a href="#">diagnostic errors</a> resulting in harm, including the frequency and severity assessment of each of those errors using a severity scale such as the <a href="#">National Coordinating Council for Medical Error and Reporting Index</a> .
<input type="radio"/>	Our hospital conducts annual qualitative interviews with <a href="#">clinicians</a> , including nurses and pharmacists, allied health professionals, and others involved in the diagnosis process to identify systemic problems in the <a href="#">diagnostic process</a> .
OTHER	_____

**Domain 1: Leadership Structures and Systems**

Recommended Practice 1.4B

<p><b>14: As it specifically relates to reducing errors in diagnosis (including delayed, wrong, or missed diagnoses, and diagnoses not communicated to the patient), what is your hospital’s progress in implementing practice 1.4B?</b></p> <p>Practice 1.4B: <a href="#">Senior administrative leaders</a> put processes and structures in place to identify, track, and analyze errors in diagnosis, including errors that result in harm or death, with a focus on high-risk areas of the hospital (e.g., ED, labor and delivery units, critical care units), and regularly communicate performance and progress on improvement initiatives with their board of directors.</p> <p><i>If “not under consideration,” continue to question 15. Otherwise, move on to question 14a.</i></p>				
<i>Not under consideration</i>	<i>Exploring and Preparing</i>	<i>Planning and Resourcing</i>	<i>Implementing and Operationalizing</i>	<i>Fully Implemented and Evaluating Impact</i>

**14a: Were any of the following resources or strategies used on your path to implement Practice 1.4B? If you used a resource or strategy not listed here, select “Other” and provide a brief description.**

**Select all that apply.**

o	<a href="#">Senior administrative leaders</a> deploy electronic trigger tools to mine EHRs for <a href="#">diagnostic errors</a> , assign individual case analysis to extract learnings, and share learnings and opportunities for improving the <a href="#">diagnostic process</a> .
o	<a href="#">Senior administrative leaders</a> ensure that data from incident reports, patient complaints, malpractice suits, and autopsies are used to identify diagnosis-related harm.
o	<a href="#">Senior administrative leaders</a> take action to encourage both patient and staff-reported <a href="#">diagnostic errors</a> and concerns and put systems in place for psychologically safe and easy to use reporting.
o	<a href="#">Senior administrative leaders</a> can regularly monitor performance on nationally endorsed measures of quality of care in diagnosis (see examples on page 45 of the <a href="#">Recognizing Excellence in Diagnosis Recommended Practices Report</a> ).
OTHER	_____

**Domain 1: Leadership Structures and Systems**

Recommended Practice 1.4C

<p><b>15: As it specifically relates to reducing errors in diagnosis (including delayed, wrong, or missed diagnoses, and diagnoses not communicated to the patient), what is your hospital’s progress in implementing practice 1.4C?</b></p> <p>Practice 1.4C: The hospital has a process in place to identify and address features of the EHR (e.g., storage of laboratory results, workflows, display of patient data and messaging capabilities) that may contribute to <a href="#">diagnostic errors</a>.</p> <p><i>If “not under consideration,” continue to question 16. Otherwise, move on to question 15a.</i></p>				
<i>Not under consideration</i>	<i>Exploring and Preparing</i>	<i>Planning and Resourcing</i>	<i>Implementing and Operationalizing</i>	<i>Fully Implemented and Evaluating Impact</i>

**15a: Were any of the following resources or strategies used on your path to implement Practice 1.4C? If you used a resource or strategy not listed here, select “Other” and provide a brief description.**

**Select all that apply.**

<input type="radio"/>	On an annual basis, our hospital actively seeks formal input from clinical staff on their satisfaction with the EHR and their recommendations to improve features that will reduce <a href="#">diagnostic errors</a> and improve the <a href="#">diagnostic process</a> . For example, these activities are performed as part of annual self-assessments based on the ONC-sponsored <a href="#">SAFER Guides</a> .
<input type="radio"/>	Our hospital has a workgroup or small committee of both health IT and clinical staff that meets at least quarterly to discuss active concerns with the EHR’s configuration and how to address them.
<input type="radio"/>	In setting the annual IT budget for our hospital, administrators and budget managers ensure items that correspond to initiatives to resolve diagnostic safety issues identified in the EHR, and regularly review the items to ensure those funds are being disbursed.
<input type="radio"/>	Just-in-time decision support systems are used, when available, to support diagnosis for common medical complaints or scenarios. For example, the <a href="#">Pediatric Emergency Care Applied Research Network (PECARN) Clinically Important Traumatic Brain Injury</a> decision tool is integrated within the emergency department’s EHR to help make decisions about neuroimaging for head trauma in children in the emergency department.
OTHER	_____

**Domain 1: Leadership Structures and Systems**

Recommended Practice 1.5A

**16: As it specifically relates to reducing errors in diagnosis (including delayed, wrong, or missed diagnoses, and diagnoses not communicated to the patient), what is your hospital’s progress in implementing practice 1.5A?**

Practice 1.5A: [Clinicians](#) and [others involved in the diagnostic process](#) have protected time to participate in activities that help improve the [diagnostic process](#), which at a minimum includes:

- Analyzing patient-reported concerns and diagnostic safety outcomes data,
- Documenting and sharing what is learned with others, and
- Using the documented information to develop and implement improvement activities.

*If “not under consideration,” continue to the Additional Questions. Otherwise, move on to question 16a.*

<i>Not under consideration</i>	<i>Exploring and Preparing</i>	<i>Planning and Resourcing</i>	<i>Implementing and Operationalizing</i>	<i>Fully Implemented and Evaluating Impact</i>
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**16a: Were any of the following resources or strategies used on your path to implement Practice 1.5A? If you used a resource or strategy not listed here, select “Other” and provide a brief description.**

**Select all that apply.**

<input type="radio"/>	One or more <a href="#">clinicians</a> from our hospitalist service or ED are allocated dedicated time to participate in diagnostic improvement activities. These individuals work with the safety, quality, and risk management staff to evaluate reports of diagnostic concerns, help conduct and analyze diagnostic safety checklists and surveys, and collaborate in developing improvement programs.
<input type="radio"/>	<a href="#">Clinicians</a> and <a href="#">others involved in the diagnostic process</a> have protected time to participate on interdisciplinary diagnostic safety teams and participate in team activities.
<input type="radio"/>	<a href="#">Clinicians</a> and <a href="#">others involved in the diagnostic process</a> have protected time to participate in training and educational programs.
OTHER	_____

Additional Questions (optional)

<b>From your perspective, which single practice will drive the greatest improvement in reducing errors in diagnosis (including delayed, wrong, or missed diagnoses, and diagnoses not communicated to the patient) at your hospital?</b>
<b>From your perspective, which single practice will have the least impact on reducing errors in diagnosis (including delayed, wrong, or missed diagnoses, and diagnoses not communicated to the patient) at your hospital?</b>
<b>What are the main barriers your hospital faces in implementing one or more of the <a href="#">recommended practices</a>?</b>
<b>What would accelerate the implementation of one or more of the <a href="#">recommended practices</a>?</b>
<b>Who was part of the team that completed the Pilot Survey? (titles/roles, not individual names)</b>

## **Domain 1: Leadership Structures and Systems**

### Register for a Roundtable Discussion

Pilot participants are invited to participate in a roundtable discussion to provide Leapfrog with additional feedback on the recommended practices included in the Pilot Survey and/or the Society to Improve Diagnosis in Medicine (SIDM) with additional feedback on the SIDM Playbook. These roundtables are optional, but all participants are welcome.

Use the links below register.

**Pilot Survey Roundtables – These roundtables will focus on the recommended practices included in the Pilot Survey:**

- January 17 at 2:00 PM EST  
[https://leapfroggroup.zoom.us/meeting/register/tZYvcuyogTlvGtb\\_7JBkbTw9MXLoyWpeeGIH](https://leapfroggroup.zoom.us/meeting/register/tZYvcuyogTlvGtb_7JBkbTw9MXLoyWpeeGIH)
- January 19 at 11:00 AM EST  
<https://leapfroggroup.zoom.us/meeting/register/tZYrduqvqDgsH9CJL23glweZo2OjxnE1LSJO>
- January 25 at 2:00 PM EST  
<https://leapfroggroup.zoom.us/meeting/register/tZwsf--qqz4pHNXK4UUzijiwta4OIEOxNPZB>

**SIDM Playbook Roundtables – These roundtables will focus on the SIDM Playbook for PFAC engagement:**

- January 23 at 11:AM EST  
<https://leapfroggroup.zoom.us/meeting/register/tZEqceyrrjwvGdYnzJLaKGbWDYkQsurJ06WE>
- January 24 at 1:00 PM EST  
<https://leapfroggroup.zoom.us/meeting/register/tZUvduyprijwuHtUr7ReEUorMmYAdm6DpvDX9>



Thank you for participating in the Recognizing Excellence in Diagnosis Pilot Survey.

You will receive a confidential benchmarking report in March. In the meantime, if you have any questions, want to register for a different roundtable session, or need a PDF copy of your responses, please contact the [Help Desk](#).