SIDM Survey on Diagnostic Error

Q1.1 I am aware of the recommendations made by the National Academy of Medicine (Institute of Medicine) in their report Improving Diagnosis in Healthcare, released in September, 2015.

- ❍ strongly agree
- ❍ agree
- ❍ neutral
- ❍ disagree
- ❍ strongly disagree

Q1.2 Diagnostic errors will likely affect each of us in our lifetime.

- ❍ strongly agree
- ❍ agree
- ❍ neutral
- ❍ disagree
- ❍ strongly disagree

Q1.3 Medical misdiagnosis is mainly an individual physician cognitive issue, not a systems issue.

- ❍ strongly agree
- ❍ agree
- ❍ neutral
- ❍ disagree
- ❍ strongly disagree

Q1.4 Leadership and safety officials at my institution have a thorough understanding of the science of diagnostic safety (e.g., definitions, principal causes, available solutions, etc.).

- ❍ strongly agree
- ❍ agree
- ❍ neutral
- ❍ disagree
- ❍ strongly disagree

Q2.1 Since diagnosis is inherently uncertain, most misdiagnoses are probably not preventable.

- ❍ strongly agree
- ❍ agree
- ❍ neutral
- ❍ disagree
- ❍ strongly disagree

Q2.2 Our safety program is competent in conducting a root cause analysis of a case of diagnostic error, including consideration of both the human factors and cognitive elements.

- ❍ strongly agree
- ❍ agree
- ❍ neutral
- ❍ disagree
- ❍ strongly disagree

Q2.3 Diagnostic errors are a daunting problem. My institution's quality and patient safety programs would require substantial new resources to address diagnostic errors.

- ❍ strongly agree
- ❍ agree
- ❍ neutral
- ❍ disagree
- ❍ strongly disagree

Q2.4 Implementing programs to solve the diagnostic error problem will likely result in massive overuse of diagnostic tests, leading to over-diagnosis and wasted resources.

- ❍ strongly agree
- ❍ agree
- ❍ neutral
- ❍ disagree
- ❍ strongly disagree

Q3.1 The physician staff at my institution are currently interested (or would be receptive) to begin addressing the problem of diagnostic error.

- ❍ strongly agree
- ❍ agree
- ❍ neutral
- ❍ disagree
- ❍ strongly disagree

Q3.2 My institution is actively seeking to address diagnostic accuracy and error in the next six months.

- ❍ strongly agree
- ❍ agree
- ❍ neutral
- ❍ disagree
- ❍ strongly disagree

Q3.3 Our institution's patient safety program has made misdiagnosis a top priority, devoting resources in proportion to the frequency and severity of misdiagnosis-related harms.

- ❍ strongly agree
- ❍ agree
- ❍ neutral
- ❍ disagree
- ❍ strongly disagree

Q3.4 I believe that my institution will measurably reduce diagnostic errors in the next three years.

- ❍ strongly agree
- ❍ agree
- ❍ neutral
- ❍ disagree
- ❍ strongly disagree

Q4.1 What do you see as the primary barriers at your institution to reducing diagnostic errors? Please click and drag up to FOUR items into the "Primary Barriers" box.

Primary Barriers
_____ lack of awareness of the diagnostic error problem
_____ lack of solutions to reduce diagnostic errors
_____ lack of measures of diagnostic accuracy/error
_____ lack of feedback on diagnostic performance
_____ lack of publicly reported measures (suggesting a lower overall priority)
_____ a reimbursement system that does not encourage innovation to improve diagnosis
_____ lack of buy-in from executives
_____ lack of personnel who have the knowledge, skills, and/or interest
_____ patient safety fatigue/exhaustion – yet ANOTHER patient safety problem
_____ inadequate teamwork or sociocultural divide between diagnosing physicians and other professionals (e.g., nurses, who are generally prohibited from making medical diagnoses)
_____ institutional risk management or medicolegal concerns related to disclosure
_____ 'unsafe' reporting culture (i.e., fear of backlash with disclosure)
_____ other

Q4.2 Is someone at your institution tasked specifically with reducing diagnostic errors?

- ❍ Yes
- ❍ No

Q4.3 Approximately how many full-time equivalent employee (FTE) units are focused on reducing diagnostic errors? For example, if one safety officer has 25% support for diagnostic safety and quality, FTE = 0.25.

- ❍ None
- ❍ 0.01-0.10
- ❍ 0.11-0.25
- ❍ 0.26-0.50
- ❍ 0.51-1.0
- ❍ >1.0

Q4.4 Approximately how many diagnostic error-related quality or safety projects has your institution undertaken in the past 12 months?

- ❍ None
- ❍ 1-2
- ❍ 3-5
- ❍ 6-10
- ❍ >10

Q4.5 Approximately what percentage of the groups, divisions, departments, or other entities within your institution is required to routinely (at least annually) report their diagnostic performance to executive leadership?

- ❍ None
- ❍ 1-10%
- ❍ 11-25%
- ❍ 26-50%
- ❍ 51-75%
- ❍ 76-90%
- ❍ >90%

Q4.6 Which of the following tools do you believe will be the most important for improving diagnostic accuracy and reducing harms from diagnostic error at your institution? Place a 1, 2, and 3 next to the items you rank as most important (1 being most important).

_____ Patient engagement/empowerment
_____ Enhanced teamwork & communication
_____ Culture change to emphasize diagnostic safety
_____ Closed-loop test results reporting (e.g., direct-to-patient)
_____ Feedback on diagnostic accuracy/performance
_____ Educational interventions/training for physicians
_____ Computer-based diagnostic decision support/decision aids
_____ Novel diagnostic tests (e.g., 'wearables' or new imaging techniques)
_____ Precision diagnostic medicine (genetics, genomics, proteomics)
_____ Health delivery system change/access
_____ Health system payment reform (e.g., global budgeting)
_____ Other

Q4.7 Please describe any significant efforts or progress your institution has made toward reducing diagnostic errors or improving diagnostic safety and quality.

Q4.8 What are your institution's biggest fears and concerns around the issue of tackling diagnostic errors/ safety?

Q4.9 Please provide any additional comments or feedback on the topic of diagnostic errors/ safety.

Q4.10 Please provide any additional comments or feedback about this survey.

Q5.1 What type of institution do you work at (the one on whose behalf you are responding)?

- ❍ academic health system/ university hospital
- ❍ self-insured/ integrated health network (e.g., Kaiser, Intermountain, Geisinger)
- ❍ standalone community hospital
- ❍ critical access hospital
- ❍ free-standing pediatric hospital
- ❍ specialty hospital (e.g., cancer, orthopedic, cardiac)
- ❍ other _____

Q5.2 What is the dominant financial model at your institution?

- ❍ fee-for-service
- ❍ bundled/ service-line payments
- ❍ capitation/ population-based budgeting
- ❍ other _____

Q5.3 About how many employees work at your institution? (give your best estimate)

- ❍ 1-10
- ❍ 11-24
- ❍ 25-99
- ❍ 100-499
- ❍ 500-999
- ❍ 1,000-4,999
- ❍ 5,000-24,999
- ❍ >=25,000

Q5.4 Does your institution have a formal patient safety institute or center?

- ❍ Yes
- ❍ No

Q5.5 What is your role at your institution?

- ❍ chief executive officer
- ❍ chief medical officer
- ❍ chief patient safety officer
- ❍ chief quality officer
- ❍ other patient safety officer
- ❍ director of quality
- ❍ other _____

Q5.6 If you are willing to be contacted about your institution's experiences with diagnostic errors, please provide your email address below.