{PLENARY SESSION}\nResearch Summit: Improving Diagnosis in Health Care\n
Jeffrey Brady, MD, MPH\nDirector, Center for Quality Improvement and Patient Safety\nAHRQ Research Summit on Diagnostic Safety\nSeptember 28, 2016
• 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)

<table>
<thead>
<tr>
<th>Year</th>
<th>All Other HACs</th>
<th>(Post-op) Venous Thromboembolisms</th>
<th>Ventilator-Associated Pneumonias</th>
<th>Surgical Site Infections</th>
<th>Pressure Ulcers</th>
<th>Obstetric Adverse Events</th>
<th>Falls</th>
<th>Central Line-Associated Bloodstream Infections</th>
<th>Catheter-Associated Urinary Tract Infections</th>
<th>Adverse Drug Events</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>145</td>
<td>27.3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>49.5</td>
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<tr>
<td>2011</td>
<td>142</td>
<td>26.7</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>48.7</td>
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<tr>
<td>2012</td>
<td>132</td>
<td>25.7</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td>41.9</td>
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<tr>
<td>2013</td>
<td>121</td>
<td>25.1</td>
<td>2.4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td>40.3</td>
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<tr>
<td>Interim 2014</td>
<td>121</td>
<td>2.4</td>
<td>2.4</td>
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<td></td>
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<td>41.4</td>
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<tr>
<td>PFP HAC Rate Goals</td>
<td>120</td>
<td>2.4</td>
<td>2.4</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>40.8</td>
</tr>
</tbody>
</table>
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

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
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.
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

AHRQ Products Applicable to Improving Diagnostic Safety

- TeamSTEPPS
- Questions Are the Answer
- Hospital Guide to Patient and Family Engagement
(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
    o Patient and Family Engagement
    o Professional Education and Training

• Highlights in afternoon, full-group session in order to “reassemble” parts of the system and consider next steps