

Improving Diagnosis



Diagnostic error is a significant and under-recognized threat to patient safety.

- Diagnostic errors affect more than 12 million Americans each year and may seriously harm approximately 4 million.
- Fifty-five percent of patients said diagnostic errors were a chief concern in outpatient visits.
- Most patients will experience at least one diagnostic error in their lifetime, according to the AHRQ-sponsored report, *Improving Diagnosis in Health Care*, published by the National Academy of Medicine: <http://www.nationalacademies.org/hmd/Reports/2015/Improving-Diagnosis-in-Healthcare>
- Errors occur in all settings of care, contribute to about 10 percent of patient deaths, and are the primary reason for medical liability claims.

AHRQ is a key leader in the effort to combat this problem.

Research

Since 2007, AHRQ has invested in research to discover findings that advance the field's knowledge of diagnostic safety and to develop practical tools and resources to reduce diagnostic error. AHRQ is also funding research to better understand how diagnostic errors happen, what can be done to prevent them, and how this information can be integrated into practice to improve the care and safety of patients.

The September 2016 AHRQ Research Summit on Improving Diagnosis in Health Care: www.ahrq.gov/news/events/ahrq-research-summit-diagnostic-safety.html explored the state of the science of diagnosis in health care. Experts discussed ways AHRQ and other stakeholders can contribute to a collaborative approach to identify the research and evidence, tools and training, and data and measures that are needed to improve diagnostic performance. More information on AHRQ's studies on diagnostic error can be found at: www.ahrq.gov/topics/diagnostic-safety-and-quality.html. Additional studies and resources can be found by visiting AHRQ's PSNet website: <https://psnet.ahrq.gov/> and searching for diagnostic error.

Defining the Scope of Diagnostic Errors

Recognizing that all Americans can be affected by diagnostic errors, Congress authorized \$2 million in fiscal year 2019 for AHRQ to initiate a research agenda to understand and solve the problem. AHRQ began this effort by issuing a funding opportunity announcement: <https://grants.nih.gov/grants/guide/rfa-files/RFA-HS-19-003.html> on March 22, 2019, to support research that will more precisely define the scope of diagnostic errors. It outlines three key areas of interest:

- Quantifying the incidence of diagnostic errors.
- Understanding what contributes to these errors.
- Learning more about the link between diagnostic errors and outcomes, including adverse events.



Tools

AHRQ's tools to reduce diagnostic error include:

Guide to Patient and Family Engagement. This guide encourages hospital patients and family members to be involved in their care. It focuses on four primary strategies for promoting patient/family engagement in hospital safety and quality of care:

- Encourage patients and family members to participate as advisors.
- Promote better communication among patients, family members, and health care professionals from the point of admission.
- Implement safe continuity of care by keeping the patient and family informed through nurse bedside change-of-shift reports.
- Engage patients and families in discharge planning throughout the hospital stay.

Web: www.ahrq.gov/professionals/systems/hospital/engagingfamilies/index.html

Guide to Improving Patient Safety in Primary Care Settings by Engaging Patients and Families offers four interventions and four case studies designed to improve patient safety by meaningfully engaging patients and families in their care.

Web: www.ahrq.gov/pfprimarycare

Improving Your Laboratory Testing Process: A Step-by-Step Guide for Rapid-Cycle Patient Safety and Quality Improvement Studies of primary care offices consistently show that the process for managing medical tests is a significant source of error and patient harm. This toolkit helps ensure that tests are accurately managed and shared with patients and clinicians in a timely manner.

Web: www.ahrq.gov/professionals/quality-patient-safety/hais/tools/ambulatory-care/labtesting-toolkit.html

Questions Are the Answer. Patients and families who engage with providers ask good questions and help reduce the chance of mistakes, tests that are not needed, and avoidable hospital stays. AHRQ has a collection of resources, including a Question Builder app: <https://www.ahrq.gov/patient-safety/question-builder.html>, which assist patients in creating their list of questions before appointments.

Web: www.ahrq.gov/patients-consumers/patient-involvement/ask-your-doctor/index.html

Reducing Diagnostic Errors in Primary Care Pediatrics Toolkit. This toolkit walks primary care practice teams through the measurement, screening, recognition, diagnosis, follow up, and reduction of diagnostic errors in elevated blood pressure, adolescent depression, and actionable pediatric diagnostic tests. It is based on clinical evidence and best practices from more than 100 primary care physicians and their care teams working across the United States.

Web: www.ahrq.gov/professionals/quality-patient-safety/diagnostic-safety/toolkit.html

Resources to Facilitate Communication Between Patients and Clinicians. From the Institute of Medicine "Improving Diagnosis in Health Care," this toolkit includes a checklist and other resources to help patients understand what they can do to prevent diagnostic error.

Web: www.nationalacademies.org/hmd/Reports/2015/Improving-Diagnosis-in-Healthcare/Improving-Diagnosis.aspx

TeamSTEPPS®. This evidence-based program is helps clinical teams improve communication and coordination, making patient care safer.

Web: www.ahrq.gov/teamstepps/index.html



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