



Midwest Alliance
FOR PATIENT SAFETY

Now is the Time to *ACT for Better Diagnosis*[™]

Every nine minutes...someone in a U.S. hospital dies due to a medical diagnosis that was wrong or delayed. In fact, researchers estimate that it adds up to as many as 80,000 hospital deaths each year. Physicians get it right, on average, 90 percent of the time, but for the one in 10 diagnoses that are missed or delayed, there can be devastating consequences. It's a serious problem in the U.S. healthcare system that can lead to significant patient harm, and it hasn't been talked about enough—until now.

Midwest Alliance for Patient Safety is proud to be working with more than 40 prominent healthcare and patient advocacy organizations as part of the Coalition to Improve Diagnosis to launch a targeted effort to improve the quality of medical diagnoses. [**ACT for Better Diagnosis**](#) is an initiative that aims to improve the diagnostic process by identifying and spreading practical steps to better ensure diagnoses are **A**ccurate, **C**ommunicated and **T**imely.

Working in collaboration over several months, members of a coalition led by the Society to Improve Diagnosis in Medicine, identified a number of obstacles that we collectively believe impede diagnostic accuracy, including:

- **Incomplete communication during care transitions**—When patients are transferred between facilities, physicians or departments, there is potential for important information to slip through the cracks.
- **Lack of measures and feedback**—Unlike many other patient safety issues, there are no standardized measures for hospitals, health systems, or physicians to understand their performance in the diagnostic process, to guide improvement efforts or to report diagnostic errors. Providers rarely get feedback if a diagnosis was incorrect or changed.
- **Limited support to help with clinical reasoning**—With hundreds of potential explanations for any one particular symptom, clinicians need timely, efficient access to tools and resources to assist in making diagnoses.
- **Limited time**—Patients and their care providers overwhelmingly report feeling rushed by limited appointment times, which poses real risks to gathering a complete history that is essential to formulating a working diagnosis and allows scant opportunity to thoroughly discuss any further steps in the diagnostic process and set appropriate expectations.

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- **The diagnostic process is complicated**—There is limited information available to patients about the questions to ask, or whom to notify when changes in their condition occur, or what constitutes serious symptoms. It's also unclear who is responsible for closing the loop on test results and referrals, and how to communicate follow-up.
- **Lack of funding for research**—The impact of inaccurate or delayed diagnoses on healthcare costs and patient harm has not been clearly articulated, and there is a limited amount of published evidence to identify what improves the diagnostic process.

In response, each member organization pledged to take action to improve the accuracy and timeliness of diagnoses, naming tactics like providing online tools that help physicians recognize and avoid diagnostic pitfalls, improving medical education for new practitioners, and reducing the time an accurate diagnosis takes.

As part of MAPS' educational efforts, our team has offered diagnostic error collaborative events dating back to March 24, 2016. **Paul L. Epner, MBA, MEd, Executive Vice President and CoFounder & Director, Society to Improve Diagnosis in Medicine** presented at a Diagnostic Errors Safe Table. [\(See the Agenda\)](#) In August of this year, we hosted a webinar featuring **Dr. Hardeep Singh, M.D., M.P.H.** Chief, Health Policy, Quality & Informatics Program, Center for Innovations in Quality, Effectiveness and Safety, Michael E. DeBakey VA Medical Center Director, Houston DISCOVERY (Diagnosis Improvement Safety Center) Professor, Department of Medicine, Section of Health Services Research, Baylor College of Medicine. [\(See the Agenda\)](#) Dr. Singh is nationally known for his work on the impact of delay or failure to treat a condition in relationship to diagnostic errors.

Diagnosis involves many people and processes working together—from the patient who relays symptoms and medical history, to the physician who formulates a likely explanation and orders tests, to the laboratory scientist who provides test results, to the nurse or physician who reports them back to the patient, and to the healthcare systems and patient safety organizations whose job it is to monitor and find areas to improve the diagnostic process. By working together, we can improve the diagnostic process, but it won't happen overnight. The complexity of the diagnostic process and the interdisciplinary approaches needed to improve accuracy requires disciplined and sustained work in the coming years, with a deep engagement of diverse stakeholders.

In addition to the commitment of many players across healthcare, more government research is needed on what causes, and can prevent diagnostic errors. The FY 2018 Omnibus Appropriations Act included language emphasizing that improved diagnosis is a "moral, professional, and public health imperative" and

requested that “the Agency for Healthcare Research and Quality (AHRQ) convene a cross-agency working group to propose a strategy to enhance scientific research to improve diagnosis in healthcare.” The report also recommended including consideration of opportunities for public-private partnerships and the development of centers of excellence to propel research forward to improve diagnostic quality and safety.

To learn more about *ACT for Better Diagnosis* or to find out how you or your organization can get involved, visit www.BetterDiagnosis.org.

If you’re already taking action to improve diagnosis, share it **@ImproveDX** and use the hashtag **#betterdiagnosis**.